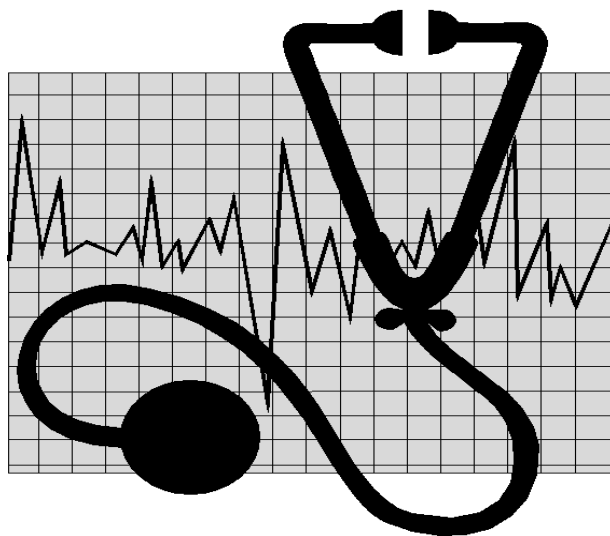


Kansas Health Insurance Information System (KHIIS)



**Progress Report
September 2000**

The Kansas Health Insurance Information System (KHIIS)

Database to Support the Insurance Commissioners Statistical Plan

Prepared By

**The Kansas Department of Health and Environment
Center for Health and Environmental Statistics
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and

The Kansas Insurance Department

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The Kansas Health Insurance Information System Background

During the late 1980s the Kansas Insurance Department (KID) realized that sound, objective health information available for informed health decision making was limited. Subsequently, the Insurance Commission sought authority to establish an insurance statistical plan, modeled after the Fire and Casualty statistical plan implemented in the 1980s. In 1989, the Kansas legislature approved the development of a statistical plan for health insurance. Tillinghast consulting firm staff met with representatives from the Kansas Insurance Department, the Health Insurance Association of America, and the National Association of Independent Insurers to discuss the objectives of the Statistical Plan, the insurance products to be included, and approaches to data collection. Several issues related to the data collection process were discussed such as use of the data, appropriateness of the data and possible compliance problems. At the time, no mechanism was in place for collection of data needed to implement the statistical plan.

During health care reform debates, the legislature found that health information was not available for its decision-making needs. The Kansas Health Insurance Information System (KHIS) was created in 1994 to assist the legislature and the Insurance Commissioner in making decisions related to health insurance premium and benefit costs in Kansas (K.S.A. 40-2251, see Appendix A).

Through its responsibility as administrator of the state's new health care database, KHIS was to be administered by the Kansas Department of Health and Environment (KDHE). Funded through assessments on insurance carriers, KHIS was established to gather information to be used to "determine whether premium rates are reasonable in relation to the benefits provided and to identify any benefits or provisions that may be unduly influencing the cost of health insurance for Kansas." Additionally, KHIS was created to assist policy makers, program managers, researchers, providers and interested parties in making informed health decisions.

The Insurance Commissioner convened an advisory group consisting of insurance industry professionals, health care providers and state agency representatives to guide a technical team consisting of KDHE and Miller and Newberg actuarial staff. It was agreed that the database would:

- Contain claims data to be used for policy analyses,
- Contain no patient or provider identifiers, but would retain a unique identifier (encrypted number) for each,
- Contain data collected from the 20 largest insurance carriers regulated by the Commissioner,
- Protect certain proprietary information such as company specific charges for services, and
- Make available information to insurance providers in aggregate form.

A methodology for collecting health insurance data was developed focusing on data collection for medical expense coverages, including Medicare supplemental policies. Disability income, hospital indemnity, accident only, cancer specialty (cancer riders) products and long term care products were not included in plans for data collection.

During the five years since implementation of the statistical plan, accomplishments include:

- Development of a technical manual with a standard for data submission,
- Collection of data due to divestitures/acquisition (now from 30 companies),
- Design of standard reports for public distribution,
- Approval of rules and regulations guiding data collection and release (see Appendix B),
- Acquisition of regional and local data for normative comparisons, and
- Provision of information for legislative committees for proposed insurance coverage mandates on prostate cancer screening, medical equipment, breast reconstructive surgery, among other topics.

Although the KHIIS database is valuable, it has limitations as there are with any claims database. These include:

- Lack of clinical data availability, which limits depth of information maintained on quality of care,
- Absence of individual provider information, thus making provider comparisons impossible,
- In some cases, absence of claims reported to the database for particular conditions. Estimates for costs to mandate benefits related to those specific conditions are not available.
- Small portion of the population; no ERISA business.

Despite the above listed weaknesses, data maintained in KHIIS are powerful in that the database makes available information on cost and utilization across provider settings. This information is being used for policy analyses that evaluate health benefits provided in policies sold to Kansans. KHIIS is a unique database for state government and will serve the Commissioner and the legislature well as future health care policy decisions are made. Data collection from existing collection systems will provide information on Kansas insured population and on outpatient and ambulatory health delivery settings in a cost-effective and efficient manner.

The Database

Data Submission and Collection

The FY 1999 KHIIS database consists of the 20 largest health insurance carriers providing private health insurance coverage for Kansans. Data contributors consist of those carriers regulated by KID; no Employee Retirement Income Security Act (ERISA) plan data are available. Based on the 1998 Premium Volume report prepared by the Kansas Insurance Department, KHIIS represents health insurance information for 80.41% (see Appendix C) of the total premium volume (assuming all carriers are submitting data properly formatted). Premium volume for 1998 totaled \$1,422,161,631. The Office of Health Care Information (OHCI) staff continue to provide technical assistance to insurance carriers as they prepare programming to format data for submission meeting defined requirements.

Processing and Editing the Data

A process has been developed for handling submitted data and a series of edits have been prepared to address data problems and inconsistencies. The process of obtaining data consists of a number of steps. Companies are sent a request for data along with an accompanying technical manual containing data submission requirements. Data received is processed by the Office of Information Systems (OIS). Problematic data is identified and returned to companies for replacement. Readable data is placed in the KHIIS database and is edited by OIS. Data is then reviewed by an analyst at OHCI and feedback on data preparation is provided to the submitting company (see Appendix E). To date, most companies are able to provide the required data, however, further work continues with companies who remain in programming modification stages.

Standard Reports

Preliminary specifications for standard reports are being prepared (see Appendix F). These are based on examples derived from nationally prepared reports and input from insurance carriers and insurance experts (see Appendix G and H). These standard reports are commonly used actuarial reports to monitor the insurance industry.

Products

During FY 1999, a number of products were created from the KHIIS database answering critical questions about the cost of:

- Mandating breast reconstruction following mastectomy (HB 2297, 1997 Session),
- Mandating mental health parity (HB2138, 1997 Session),
- Mandating coverage limits on durable medical equipment (SB509, 1998 Session),
- Requiring non-network providers chosen by the insured to be reimbursed at ninety percent of the network providers rate (SB331, 1997 Session), and
- Providing one-time coverage for vitro fertilization on the same basis as other pregnancy benefits (SB663, 1998 Session).

Response to these questions has assisted in addressing previously identifiable objectives for the KHIIS database. The statistical plan was charged with responsibility for:

- Determining if rates are reasonable in relation to benefits provided,
- Identifying benefits or provisions that may unduly influence premium cost,
- Reviewing and comparing utilization patterns, costs, quality and quantity by health care services, and
- Conducting research, policy analyses and report preparation describing the performance of the health and delivery system and making the information publically available.

Insurance Mandates Evaluated Using, Data from KHIIS

Mandatory Breast Reconstruction (SB3, 1999 Session)

Mandating insurance companies to provide coverage for breast reconstruction following mastectomy has been controversial. KHIIS data extraction used in conjunction with national averages allowed impact extrapolation of such a mandate by KDHE and Miller and Newberg Actuarial firm. Findings were:

- KHIIS shows a mastectomy rate of 3.5 per 10,000 for women aged 20-65. This rate is considerably lower than the national average. Assuming the Kansas rate and an average additional payment of \$7,000, the average premium per woman would increase about 0.2%, roughly 30 cents per year. The percentage increase would be half for cases where the insured and spouse are both covered.
- If the national average rate were applied to Kansas, the average premium increase would be approximately 0.3% and \$0.50 per year, respectively.
- The initial impact of HB 2297 may be somewhat higher since it requires coverage even when the mastectomy was performed prior to the date of coverage. It is assumed here that 60% of women with mastectomies will use reconstruction.

Mental Health Parity (SB160, 1999 Session)

Mandating insurance companies to provide coverage on the same basis as most other medical conditions for a select list of mental diagnoses has been widely debated. Findings were:

- The KHIIS database shows that about 0.8% of Kansas health claim payments in 1997 were for these diagnoses. If we assume that the proposed mandate would double the costs over the current mandate, premiums should increase by about 0.8%. The costs should roughly double because of the increased coinsurance, often 50% to 80%, and the longer coverage periods. However, it is not clear whether or not the bill would allow the exclusion of long-term, essentially custodial, hospital stays. If these potentially very long hospital stays are covered in full, the annual impact on costs will be larger, perhaps up 3%.
- Past work completed by Miller and Newberg with data in other states suggests an increase of about 2% premium per year.
- An off-set to the above is the federal act eliminating life-time and annual maximum dollar limits in most cases. This is estimated to increase plan costs by about 0.3% on the average.
- The best over-all estimate is an estimated increase of from 1.0% to 2.5%, depending on long-term coverage requirements.

In relation to questions of mental health parity, it is important to note that work by others examining the mental health parity bill (SB 1028) contained much higher cost estimates. Watson Wyatt Worldwide projected increases in health insurance costs averaging about 10%, while Price Waterhouse estimated 10% increases for indemnity plans (including PPO's), and 3% for HMOs. Mental health parity used a very broad definition of mental illness: including drug and alcohol abuse. Estimates were made for increased utilization (the "woodwork effect") transfers from the public to the private sector. Due to the narrow scope of HB 2138, these items were excluded from the analysis, although increased utilization and sector transfer will probably occur to a degree.

Durable Medical Equipment (SB509, 1998 Session)

The Durable Medical Equipment (DME) bill proposed to increase annual coverage limits on DME from \$1,000 to \$10,000. It proposed the addition of new equipment types previously not covered by most insurers. Using current definitions used by the Health Care Finance Administration, estimates in premium increase for increasing coverage limits was 0.85% per year.

The costs of additional equipment types was difficult to estimate due to uncertainties about the possible applicant population. It is assumed that the population would consist of individuals with long term disabilities. These are often people not insured under traditional individual or group insurance. Possible types of equipment to be covered are personal computers for the learning and physically disabled, scooters, whirlpools, adjustable beds, and the like.

Given a reasonable estimate of the insured population with or contracting covered disabilities, an upper bound of 12% increased costs per year was made. DME coverage, as defined by HCFA, would increase premiums by .84%, or 84 cents per \$1,000 of premium. This is roughly \$3 per member per year in premium.

Point of Service (SB331, 1998 Session)

This proposed bill would require non-network providers chosen by an insured to be reimbursed at 90% of the network provider rate. It was unclear how this would be calculated in cases where the reimbursement was capitated.

The KHIIS database contained no information to assist in cost estimation. Thus information was requested of Miller and Newberg actuarial firm as they have information on competitive data for plans in other states where insurers have HMOs with and without a POS option. Examining the differences in premium and applying a 90% factor, it was found that the yearly increase in premium would average approximately 15%. This percentage increase may seem higher than expected, however there is a two-fold loss of insured's control under this proposal. Exercising the POS option, the insured can be reimbursed at a fairly high rate for self-referral, but the insurer can not select or monitor non-network providers.

Infertility (SB663, 1998 Session)

SB663 bill provided for one-time coverage for in vitro fertilization on the same basis as other pregnancy benefits. No other benefits would be added to coverage.

Assuming that the average cost for *in vitro* in Kansas is \$10,000 and that five percent of women at some point may attempt an *in vitro* procedure if covered by insurance, the annual cost increase for females aged 20-40 is 2.1%. The additional premium cost increase for families in that age group would be an estimated 1% per year.

It is important to note that the success rate for *in vitro* procedures is only about 25%. Additionally, there is a hidden cost in that multiple births of low weight babies are frequent in “successful” cases, giving rise to higher neonatal costs.

Estimated Cost of Prostate Screening (K.S.A. 40-2, 164)

Assistance was requested in ascertaining the impact of a proposal to provide coverage for screening for prostate cancer on premium rates. Computing the premium impact, if any, was to be done for policies with first dollar coverage, and with deductible options of \$500 and \$1,000 with 80/20 co-payment for individual coverage, individual and spouse coverage, individual and child(ren) coverage, and individual, spouse, and child(ren) coverage.

Estimated costs for mandating insurance coverage for prostate screening were based on the following assumptions:

- Plan costs from a large health insurance carrier, procedure code 84153, without adjustment. These data appeared reasonable and in general agreement with the others. Further, they were the most complete and credible.
- The annual incidence rate of 20% for males over 50 is consistent with experience data and with the first dollar rate of a large health insurance carrier. This likely under reports total tests because of those imbedded in physicals and other tests, and cases where a deductible is present and the amount may not be claimed due to the small size.
- The number of tests performed on males under age 40 (identified by procedure code 86316) are negligible. Tests and prostate cancer, are certainly rare among males under age 50.
- An 85% loss ratio was used to estimate and aggregate impact on premiums. This is approximately the weighted average of Kansas experience in recent years. This loss ratio was applied to all demographic groups.
- A large health insurance company product premiums and claim cost data were used in this analysis.

Table A: Annual Claim Costs for Plans with 80/20 Coinsurance for Prostate Screening

	Individual	Individual and Spouse	Individual and Children	Family
No Ded Total	\$3,156	\$6,732	\$5,112	\$9,588
Test	\$7.73	\$7.73	\$7.73	\$7.73
Percent of Total	.24%	.11%	.15%	.08%
Premium \$9.10 annual, \$1.64 if spread over group.				
\$55 Ded Total	\$2,268	\$4,848	\$3,684	\$6,900
Tests	\$3.15	\$3.15	\$3.15	\$3.15
Percent of Total	.14%	.06%	.09%	.05%
Premium \$3.70 annual, \$1.67 if spread over group.				
\$1000 Ded Total	\$1,896	\$4,104	\$3,108	\$5,820
Tests	\$2.14	\$2.14	\$2.14	\$2.14
Percent of Total	.11%	.05%	.07%	.04%
Premium \$2.51 annual, \$.45 if spread over group.				

Findings indicated that premium increases varied depending on insurance plan (see Table A). Higher deductible plans impacted premium increases less in regard to mandating insurance coverage for prostate cancer screening.

Information on the Physician Reimbursement Fee Schedule

A number of issues have been discussed regarding the Medicaid physician reimbursement fee schedule, its relationship to managed care, and options for changing the fee schedule. According to a letter of January 8, 1998 prepared by SRS, in the aggregate, Medicaid physician reimbursement in Kansas is substantially below that of most state Medicaid programs, Medicare, and private insurance. Kansas rates are especially low for many primary care services, such as hospital and office visits and immunizations. The rates are substantially above average, however, for many lab, x-ray, surgical services, and for maternity care. While physicians are not required to use the Medicaid physician fee schedule to reimburse physicians, many of them do. Further, HMO capitated rates derived from the Medicaid fee schedule may not be sufficient to induce participation in the Medicaid program by as many experienced and capable HMOs as the state would like. Thus, revising the fee schedule to increase reimbursement for primary care physician services could increase access to this kind of care in

both the fee-for-service and managed care portions of the Kansas Medicaid program.

The cost of increasing rates for primary care services could be offset by reducing physician fees in other parts of the fee schedule where Kansas rates are substantially above the average of other state Medicaid programs, such as labs, x-rays, surgeries, and maternity care. Myers and Stauffer, LLC-Topeka, KS has developed a model that compares Kansas physician fees to three different benchmarks: an average of the Medicaid rates in Missouri, Iowa, Indiana, and Nebraska; Medicare fees in Kansas; and a limited sample of private insurance fees in Kansas.

Modifying Medicaid physician fees to bring them more in line with those paid by other state Medicaid programs, Medicare, and private insurers could be a useful step toward adoption of the Resources-Based Relative Value System (RBRVS) for physician reimbursement that is used by Medicare as well as about half of state Medicaid programs and an increasing number of private insurers. Even without going to a full-scale RBRVS system, a fee schedule that matched the four-state Medicaid average would significantly increase the incentives for physicians to provide primary care services. In addition, because hospital outpatient reimbursement in Kansas is tied to the physician fee schedule, a revised physician fee schedule would increase outpatient reimbursement.

Cost Associated with Hospice Care

The Kansas Insurance Department requested information regarding cost savings associated with hospice care. Health Care Information staff in consultation with Meyers and Stauffer have conducted a literature search and discussed this issue with several parties. Some useful information was found as follows:

- Contact was made with a major insurance carrier in Kansas. The representative reported that the data they provide to KHIIS will not contain hospice information because they do not include this as a benefit in their coverage package. Hospice care must be purchased as a separate rider.
- We will continue to search within KHIIS, now that we more fully understand the codes and other items to search for. This information will be provided when available.
- We have requested that Kansas Foundation for Medical Care extract hospice care information from the Medicare data system for review. An analysis of Medicare data comparing hospice care and inpatient end-of-life costs.
- Information has been gathered from a variety of articles baring on the question of hospice care cost effectiveness. It is summarized below:
 - Since end-of-life costs account for about 10% of the total health care spending and 27% of Medicare expenditure, 10% savings during the last year of life would amount to approximately \$10 billion per year in medical costs and almost \$4.7 billion for Medicare alone (2.7% savings of \$174 billion in 1995 Medicare expenditures) (Emanuel, 1996).
 - In 1995 the 2,800 U.S. hospice organizations treated nearly 15% of Americans who died (National Hospice Organization, 1998).

- A national study funded by the Robert Wood Johnson Foundation concluded that approximately 83% of employees from midsize and large firms have hospice care as an explicit benefit among their health benefit packages. Employers are supportive of the hospice concept largely due to the belief that hospice benefits reduce overall health insurance coverage cost (Gabel, 1998).
- Cost saving declines as the number of months care is used increases. Hospice care is estimated to save between 25 to 40% of health care costs during the last month of life, with savings decreasing to between 10 to 17% over the last 6 months of life and decreasing further to 0 to 10% over the last 12 months of life (Emanuel, 1996).
- “Reduced use of hospitals in the last month of life, accounts for almost 70% of savings from hospice in the last year of life” (Emanuel, 1996).
- According to Tolley and Manton (1984), 6% of Medicare enrollees die each year, 18-31% of Medicare costs are incurred by those 6%, a total of about 40% of total Medicare costs are associated with the mortality process: fatal conditions that may or may not take more than a year to end life.
- 27 to 30% of Medicare payment each year for the 5 to 6% of Medicare beneficiaries who dies in that year. The latest available figures indicate that in 1988, the mean Medicare payment for the last year of life of a beneficiary who dies was \$13,316, as compared with \$1,924 for all Medicare beneficiaries (a ratio of 6.9:1) (Emanuel and Emanuel, 1994).
- Payment for dying patients increase exponentially as death approaches, and payments during the last month of life constitute 40% of payment during the last year of life. Identical trends and ratios have been found since the early 1960s (Emanuel and Emanuel, 1994).
- In a study to determine the effects of very high cost patients on hospice financial status, it was found that high cost patients were irregularly found in hospices, while low cost patients were commonly and regularly distributed. Research illustrated that long length of stay, Medicare hospice benefit as primary payer, any hospitalization.
- During hospice stay, and cerebrovascular disease diagnosis were statistically significantly related to high cost (Bulkin, et. al., 1993).
- An overwhelming majority of hospice patients have cancer (Emanuel and Emanuel, 1994).
- A study on cost effectiveness of a Veterans Administration hospital-based home care program that case managed inpatient and outpatient care found lower Veterans Administration and private sector hospital costs (\$3,000 vs \$4,245) for the home based patients. The net per person health care costs were 13% lower for in home care (Cummings et. al., 1990).

Further Plans

The KHIIS database will be the resource for a number of future health insurance policy questions. It is unique when compared to health care data collected across the country in that data are collected across all health care delivery settings. Financing information is also maintained and reflects actual payments for services. Furthermore, this database represents an estimated 80% of the privately insured (non-ERISA) Kansas premium volume.

Considerable time has been spent developing a technical manual which has now become the standard tool for data reporting in a number of arenas. Future plans include:

- Continued standard report production,
- Expansion of data collection for ERISA when feasible,
- Securing Medicare, Medicaid and Health Wave data,
- Preparation and dissemination of ad hoc reports and data sets as approved, and
- Evaluation of the database regarding representation of managed care coverage for the state.
- Conducting analysis and comparing findings to other insurers where appropriate (such as Medicaid and Medicare beneficiaries).

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Appendix A

Enabling Legislation

40-2251. Statistical plan for recording and reporting premiums and loss and expense experience by accident and health insurers; compilation and dissemination; secretary of health and environment to serve as statistical agent; assessments; penalties for failure to report. (a) The commissioner of insurance shall develop or approve statistical plans which shall be used by each insurer in the recording and reporting of its premium, accident and sickness insurance loss and expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the commissioner and other interested parties in determining whether rates and rating systems utilized by insurance companies, mutual nonprofit hospital and medical service corporations, health maintenance organizations and other entities designated by the commissioner produce premiums and subscriber charges for accident and sickness insurance coverage on Kansas residents, employers and employees that are reasonable in relation to the benefits provided and to identify any accident and sickness insurance benefits or provisions that may be unduly influencing the cost. Such plans may also provide for the recording and reporting of expense experience items which are specifically applicable to the state. In promulgating such plans, the commissioner shall give due consideration to the rating systems, classification criteria and insurance and subscriber plans on file with the commissioner and, in order that such plans may be as uniform as is practicable among the several states, to the form of the plans and rating systems in other states.

(b) The secretary of health and environment, as administrator of the health care database, pursuant to K.S.A. 1998 Supp. 65-6804, and amendments thereto, shall serve as the statistical agent for the purpose of gathering, receiving and compiling the data required by the statistical plan or plans developed or approved under this section. The commissioner of insurance shall make an assessment upon the reporting insurance companies, health maintenance organizations, group self-funded pools, and other reporting entities sufficient to cover the anticipated expenses to be incurred by the secretary in gathering, receiving and compiling such data. Such assessment shall be in the form of an annual fee established by the secretary and charged to each reporting entity in proportion to such entity's respective shares of total health insurance premiums, subscriber charges and member fees received during the preceding calendar year. Such assessments shall be paid to the secretary and the secretary shall deposit the same in the state treasury and it shall be credited to the insurance statistical plan fund. Compilations of aggregate data gathered under the statistical plan or plans required by this act shall be made available to insurers, trade associations and other interested parties.

(c) The secretary, in writing, shall report to the commissioner of insurance any insurance company, health maintenance organization, group self-funded pool, nonprofit hospital and medical service corporation and any other reporting entity which fails to report the information required in, the form, manner or time prescribed by the secretary. Upon receipt of such report, the commissioner of insurance shall impose an appropriate penalty in accordance with K.S.A. 40-2,125, and amendments thereto.

History: L. 1990, ch. 170, § 1; L. 1994, ch. 238, § 13; L. 1995, ch. 260, § 1; July 1.

40-2252. Same; rules and regulations. The commissioner and the secretary of health and environment, jointly, may adopt rules and regulations necessary to effect the purposes of K.S.A. 40-19c09 and 40-2251, and amendments thereto.

History: L. 1990, ch. 170, § 3, L. 1994, ch. 238, § 14; July 1.

Appendix B

Regulations



Kansas Register

Ron Thornburgh, Secretary of State

Vol. 17, No. 32 August 6, 1998 Pages 1197-1220

State of Kansas

Kansas Insurance Department
Permanent Administrative
Regulations

Article 1. - GENERAL

40-145. Release of data from the insurance database. (9) Although the data collected by and furnished to the commissioner of insurance pursuant to K.S.A. 40-2251, and amendments thereto, is not an open record pursuant to K.S.A. 1997 Supp. 45-221(16), and amendments thereto, compilations of this data may be released, subject to the following limitations.

(1) These reports shall include comparative information on averages of data collected. Compilations of data shall not contain patient-identifying information or trade secrets.

(2) The raw data shall be released by the commissioner of insurance only to each data provider that has submitted that particular data to the database and that requests to see and review its data set for purposes of verifying information in the database pertaining to that data provider. These data sets shall not be made available to the public.

(3) External data used for normative values that are not within the public domain shall not be released.

(b) Any person, organization, governmental agency, or other entity may request the preparation of compilations of data collected by and furnished to the commissioner of insurance, in accordance with the following procedure and limitations.

(1) All requests for compilations of data shall be made in writing to the commissioner of insurance. The written request shall contain the name, address, and telephone number of the requester, and a description of the legitimate purpose of the requested compilation. A "legitimate purpose" is defined as a purpose consistent with the intent, policies, and purposes of K.S.A. 40-2251, and amendments, thereto. Whether or not a legitimate purpose exists may be determined by the commissioner of insurance.

(2) Each request for a compilation of data shall be reviewed by the commissioner of insurance to determine whether to approve or deny the request. A request for compilation of data may be denied by the commissioner of insurance for reasons including any of the following.

- (A) The data are unavailable.
- (B) The requested compilation is already available from another source.
- (C) The requested compilation of data would endanger patient confidentiality.
- (D) The commissioner lacks sufficient resources to fulfill the request.
- (E) The request would disclose a trade secret.
- (F) The requester has previously violated the rules for dissemination from the insurance database.
- (G) The request is not a legitimate purpose.

(3) The requester may ask for compilations of data collected by and furnished to the commissioner of insurance in a specific manner or format not already used by the commissioner. This shall include any request for subsets of information already available from the commissioner in compiled form.

(4) The requester shall be notified by the commissioner of insurance in writing of its decision within 30 days. Each denial of a request shall include a brief explanation of the reason for the denial.

(5) Determination of a fee to be charged to the requesting person, organization, governmental agency, or other entity to cover the direct and indirect costs for producing compilations shall be made by commissioner of insurance or designee in consultation with commissioner. The fee shall include staff time, computer time, copying costs, and supplies. For charging purposes, each compilation shall be considered an original. The fee may be waived at the commissioner's discretion.

(c) No person, organization, governmental agency, or other entity receiving data from the commissioner shall re-disclose or redistribute that information for commercial purposes. Any violation of this section shall result in denial of all further request to the insurance database.

(d) Any publication using data from the insurance database shall include a written acknowledgment of the Kansas insurance department. A copy of any publication of data from the insurance database shall be sent to the commissioner of insurance before its publication. (Authorized by K.S.A. 1997 Supp. 4-2251 and K.S.A. 40-221; implementing K.S.A. 1997 Supp. 40-2251; effective Aug. 21, 1998.)

Appendix C

KHIIS Database Lines of Business

**KHIIS Database Lines of Business
and Percent of Total Premium Volume-1998**

Comp any	Company Type	1997	1998	Totals	Premium Vol. % of Total
1	PPO & Indemnity	0	0	0	0.63%
		53,338	0	53,338	
		53,337	0	53,337	
2	PPO & Indemnity	0	0	0	2.05%
		0	0	0	
		458,948	0	458,948	
3	PPO, POS & Indemnity	35,546	48,865	84,411	0.82%
		126,838	91,359	218,197	
		217,373	145,659	363,032	
4	PPO, POS & Indemnity				31.09%
5	HMO	575,821	571,216	1,147,037	
		4,192,431	4,925,058	9,117,489	
		6,079,844	7,243,375	13,323,219	
6	All Lines				6.48%
7	HMO				
8	HMO				
9	All Lines	61,966	94,928	156,894	
		749,136	1,066,313	1,815,449	
		1,086,465	1,642,898	2,729,363	
10	PPO & Indemnity	20,754	8,675	29,429	0.93%
		86,078	53,421	139,499	
		154,206	97,546	251,752	
11	HMO	10,656	0	10,656	1.08%
		23,260	0	23,260	
		40,543	0	40,543	
12	PPO, POS & Indemnity				0.89%
14					0.79%
		6,955	6,703	13,658	
		65,306	37,681	102,987	
		20,988	175,470	196,458	

13	PPO	56,288 612,632 880,523	34,231 509,088 730,877	90,519 1,121,720 1,611,400	1.89%
15	HMO	27,075 10,737 29,260	0 0 0	27,075 10,737 29,260	0.00%
16		0 0 0	0 0 0	0 0 0	1.19%
17 18	PPO & Indemnity HMO	91,483 298,477 522,483	234,116 474,457 831,363	325,599 772,934 1,353,846	9.28%
19	HMO	46,791 6,352 4,129	0 0 0	46,791 6,352 4,129	6.37%
20	Indemnity and PPO	0 0 0	0 0 0	0 0 0	1.53%
21	POS & Indemnity	182,472 421,589 842,555	221,725 697,603 1,307,975	404,197 1,119,192 2,150,530	1.70%
22	PPO & Indemnity	5,157 15,632 25,293	5,246 37,188 71,128	10,403 52,820 96,421	1.56%
		1,120,964 6,661,806 <u>10,415,947</u>	1,225,705 7,892,168 <u>12,246,291</u>	2,346,669 14,553,974 <u>22,662,238</u>	68.28%
23	PPO				0.92%
24	HMO				1.21%
25	HMO				0.16%
26	PPO				0.08%
27	HMO				2.74%
28	HMO				1.00%
29	PPO, POS & HMO				2.96%
30	PPO, POS & HMO				2.43%
31	PPO				0.62%
	Grand Total				80.41%

Appendix D
Findings from Mathematica
Policy Research, Inc.

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January 8, 1998

Ann Koci
Commissioner of Adult and Medical Services
Department of Social and Rehabilitation Services
915 SW Harrison, Room 628-S
Topeka, KS 66612

Dear Commissioner Koci:

This letter summarizes the issues we have discussed regarding the Medicaid physician reimbursement fee schedule, its relationship to managed care, and options for changing the fee schedule.

SUMMARY

In the aggregate, Medicaid physician reimbursement in Kansas is substantially below that of most state Medicaid programs, Medicare, and private insurance. Kansas rates are especially low for many primary care services, such as hospital and office visits and immunizations. The rates are substantially above average, however, for many lab, x-ray, and surgical services, and for maternity care. While HMOs are not required to use the Medicaid physician fee schedule to reimburse physicians, many of them do. Further, HMO capitated rates derived from the low Medicaid fee schedule may not be sufficient to induce participation in the Medicaid program by as many experienced and capable HMOs as the state would like. Thus, revising the fee schedule to increase reimbursement for primary care physician services could increase access to this kind of care in both the fee-for-service and managed care portions of the Kansas Medicaid program.

The cost of increasing rates for primary care services could be offset by reducing physician fees in other parts of the fee schedule where Kansas rates are substantially above the average of other state Medicaid programs, such as labs, x-rays, surgeries, and maternity care. Myers and Stauffer has developed a model that compares Kansas physician fees to three different benchmarks: an average of the Medicaid rates in Missouri, Iowa, Indiana, and Nebraska; Medicare fees in Kansas; and a limited sample of private insurance fees in Kansas.

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Kansas Medicaid physician fees could be set at 84 percent of the four-state Medicaid average at no increase in cost above the current physician reimbursement expenditure level of \$62 million a year -- "budget neutral" change. For an additional cost of \$11 million a year, the Kansas fees could be set at 100 percent of the four-state Medicaid average. Setting Kansas Medicaid fees at 100 percent of Kansas Medicare physician fees would add about \$40 million a year to current Medicaid physician expenditures. Setting Medicaid fees equal to private insurance fees could cost up to \$70 million a year above the current level.

Modifying Medicaid physician fees to bring them more in line with those paid by other state Medicaid programs, Medicare, and private insurers could be a useful first step toward adoption of the Resource-Based Relative Value System (RBRVS) for physician reimbursement that is used by Medicare as well as about half of state Medicaid programs and an increasing number of private insurers¹. Even without going to a full-scale RBRVS system, a fee schedule that matched the four-state Medicaid average would significantly increase the incentives for physicians to provide primary care services. In addition, because hospital outpatient reimbursement in Kansas is tied to the physician fee schedule, a revised physician fee schedule would increase outpatient reimbursement - a goal you mentioned in our initial meetings.

BACKGROUND

The Center for Health Care Strategies (CHCS) conducted a managed care "Readiness Assessment" in Kansas in February 1997. In the course of that assessment, you expressed the concern that the capitated rates Kansas has set in its HMO managed care program (Prime Care Kansas) may not be adequate to assure access to care by Medicaid recipients. You indicated the need to compare the Kansas Medicaid rates to those of other payers. Many Medicaid physician reimbursement rates, for example, had not been changed since the 1970s, and providers complained that they were well below market rates. Since federal regulations require that the costs of Medicaid managed care programs not exceed the costs of fee-for-service Medicaid, states have only a limited ability to increase capitated rates without at the same time increasing fee-for-service rates. You also expressed the concern that low Medicaid fee-for-service physician reimbursement rates could threaten access in Kansas's planned childrens health insurance expansion, to the extent it relies on the Medicaid program.

¹ The RBRVS payment methodology was phased on for Medicare from 1992-96. It raised reimbursement levels for primary care services and lowered reimbursement levels for certain specialty services.

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Based on its readiness assessment, CHCS agreed to provide Kansas Medicaid with technical assistance in further assessing the relationship between its fee-for-service physician reimbursement system and its HMO capitated rates, and in making appropriate recommendations regarding the physician reimbursement system. I visited Kansas on October 22-23 for discussions with you, your staff, the Kansas Medical Society, and several HMOs. Since then with extensive assistance from Myers and Stauffer and your staff, I have prepared the analysis and options that are set out in this memo.

PHYSICIAN REIMBURSEMENT REFORM OPTIONS

Myers and Stauffer has constructed a model of the Kansas Medicaid physician reimbursement system that permits your staff to experiment with a wide range of modifications to the current physician fee schedule. The model will calculate the net fiscal impact of changes in any one or more of 600 procedure codes. The model permits easy comparisons on a code-by-code basis to three main benchmarks:

- The average rate paid by Missouri, Iowa, Nebraska, and Indiana (“four-state Medicaid average”)
- The Kansas Medicare fee schedule
- The rates paid by two large Kansas private insurers (one HMO and one Preferred Provider Organization (PPO))

As a starting point, I would recommend using the four-state Medicaid average. The states are similar to Kansas both geographically and demographically, and their rates are reasonably close to the national average for state Medicaid programs. The other benchmarks can be used for purposes of comparison, especially if Kansas decides to depart from the four-state Medicaid average for particular procedure codes.

The remainder of this section highlights some comparisons of the fiscal impact of the three main benchmarks, and describes in more detail the impact by type of procedure that would result from moving from the current Kansas Medicaid fee schedule to the four-state Medicaid benchmark.

As shown in the table on the next page, setting Kansas Medicaid physician fees at 84 percent of the four-state Medicaid average would be a “budget neutral” change. There would be no net increase.

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in expenditures. Setting fees at 100 percent of the four--state average would cost about \$11 million per year more than the current system².

Fiscal Impact Of Potential Modifications To Kansas Medicaid Physician Fee Schedule (\$ in Millions)

	Annual Expenditures	\$ Increase	Percent Increase
Current fee schedule	62	0	0
84% of 4-state Medicaid avg.	62	0	0
100% of 4-state Medicaid avg.	73	11	18
100% of KS Medicare	102	40	18
100% of private PPO/HMO	120-130	60-70	100-110

SOURCE: Myers and Stauffer

As shown in the table on the next page, setting Kansas physician fees at 100 percent of the four-state Medicaid average would result in increases for most types of procedures. The rates for some radiology and surgery procedures would be reduced, while others would be increased. The biggest overall dollar reductions would come in maternity procedures, where Kansas in recent years has substantially increased physician reimbursement. For all maternity procedures combined, the reduction would be about 15 percent.

² Because the Myers and Stauffer model on which these fiscal estimates are based does not include all physician reimbursement procedure codes, the actual fiscal impact of the changes could be about 10 percent above or below the estimates derived from the model.

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Selected Major Changes In Expenditures From Setting Kansas Physician Reimbursement Fees At 100% Of Four-State Medicaid Average, By Type Of Procedure

Code Range	Type of Procedure	\$ Change (In Millions)	% Change
99217-99238	Hospital care	3.0	114
99201-99215	Office visits	2.7	27
99280-99285	Emergency room visits	1.6	147
90700-90745	Immunization	0.5	174
99250-99255	Inpatient consultations	0.4	77
99240-99245	Outpatient consultations	0.4	76
70010-79999	Radiology	-0.1	-2
33010-37799	Cardiovascular surgery	-0.1	-8
59000-59899	Maternity	-2.0	-15

SOURCE: Myers and Stauffer

More Selective Modifications To The Physician Fee Schedule

Once the state decides on the overall dollar amount that is available to fund modifications to the physician fee schedule, it would be useful to consider more selective changes to the fee schedule, rather than setting all rates at some percentage of a benchmark such as the four-state Medicaid average. The Myers and Stauffer model is set up so that the fiscal impact of any combination of changes can be quickly calculated.

If, for example, the state is reluctant to make major reductions in reimbursement for maternity procedures, some of the increases in other procedures that would result from using 100 percent of the four-state Medicaid benchmark could be scaled back. Representatives of the Kansas Medical Society and the HMOs with whom the Medicaid program has contacted could likely provide valuable advice on potential trade-offs of this sort. In addition, because many of the increases from setting rates at 100 percent of the four-state Medicaid average would go to hospital based physicians and to outpatient hospital reimbursement, hospital representatives should probably also be involved in the discussions.

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Longer-Term Physician Reimbursement Reform Options

The RBRVS physician reimbursement system that Medicare is now using throughout the country is also used by about half of state Medicaid programs and a steadily increasing number of private insurers.³ The RBRVS system is scientifically based and carefully constructed. It is continually being refined and improved by the Health Care Financing Administration. The system is designed so that states can adjust the so-called “conversion factor” in the system to achieve whatever fiscal impact they wish, without modifying the rest of the system’s structural features.

One of the main purposes of the RBRVS system is to shift reimbursement resources from surgical to primary care services, or from “procedural” to “cognitive” physicians. Moving the current Kansas reimbursement fee schedule in the direction of the four-state Medicaid average would have a similar effect, although it would be less thorough and more systematic than the RBRVS system. It could therefore set the stage for a move to an RBRVS system at a future point. Developing an RBRVS system requires the investment of significant time and analytic resources, but there are models available in other state Medicaid programs that can provide good starting points. Myers and Stauffer is familiar with a number of these models, including the one now being used in the Indiana Medicaid program.

Problems With Using Currently Available Private Insurance Data As A Benchmark

As we discussed, Myers and Stauffer has received private physician fee schedule data from the Department of Health and Environment covering two HMOs and two PPOs. The data from one of the HMOs and one of the PPOs are very incomplete; only about 10-20 percent of the procedure codes overlap with the 600 physician procedure codes in the Myers and Stauffer model. There is about a 90 percent overlap in the data from the other PPO, and about a 65-70 percent overlap in the data from the other HMO. Even with these latter two fee schedules, however, there are many inconsistencies between the procedure codes in those schedules and the Medicaid codes, since insurers are not required in their commercial business to abide by the HCFA requirements for procedure code uniformity and consistency that apply to Medicaid and Medicare claims.

Nonetheless, it will be useful to have this private insurance benchmark as you look at specific procedure codes that may be especially sensitive because of their clinical or fiscal impact, such as the maternity codes. The private insurance rates have been loaded into the Myers and Stauffer model, so they are readily available for comparison to the Kansas Medicaid fee schedule.

³Martin Sean “Increasingly, payers use Medicare’s physician pay scale.” *American Medical News*, December 1, 1997.

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RELATED ISSUES

There are two related issues that are worth reiterating here: phase-in options and measurement of physician participation and recipient access.

Phase-In Options

There are some possibilities for phasing in or front-loading increases in physician reimbursement rates if budget or other circumstances warrant it. If there are funds available for increases in FY 1999, for example, but some uneasiness about the availability of funding in later years, a phase-in that limited the increase in expenditures in later years could be used. Some key physician rates could be increased in FY 1999, but offsetting reductions elsewhere in the physician fee schedule could be postponed until FY 2000 and beyond. Alternatively, Savings could be sought in other parts of the Medicaid budget to offset the costs of physician fee increases in later years. In addition, it is worth noting that if there are no further increases in physician reimbursement rates in later years, their real value will be eroded by inflation over time.

Measurement Of Physician Participation And Recipient Access

Finally, you should be sure to track physician participation and recipient access to see whether the increases in physician reimbursement have the desired impacts on access to care:

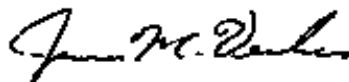
- **Physician participation.** Your claims processing system should be able to track the number of physicians who submit a specified number of claims during the course of a year, so that you can see whether that number goes up following an increase in physician reimbursement. It would be especially helpful to track this by physician specialty, since the fee schedule increase options described above are likely to have their greatest impact on primary care physicians and those involved in providing maternity care. If there is concern about the potential impact of reductions in maternity care fees on access, for example, tracking and monitoring efforts could focus in particular on physicians who specialize in maternity care.
- **Recipient access.** Recipient access is a more direct measure of the results you would presumably like to achieve with physician fee increases. Your claims processing system should be able to track measures such as the percentage of Medicaid-enrolled children receiving any physician services, the number of physician office visits per enrolled child, and the number of physician office visits per enrolled pregnant woman. It would also be useful to track emergency room visits, since improved primary care usually reduces such visits. If emergency room fees are substantially increased,

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however -- as they would be under most of the options discussed earlier -- that could result in an offsetting increase in emergency room utilization.

I hope this is helpful. Please let me know if you have any questions, or would like me to develop any of this further.

Sincerely,

A handwritten signature in cursive script, appearing to read "James M. Verdier".

James M. Verdier

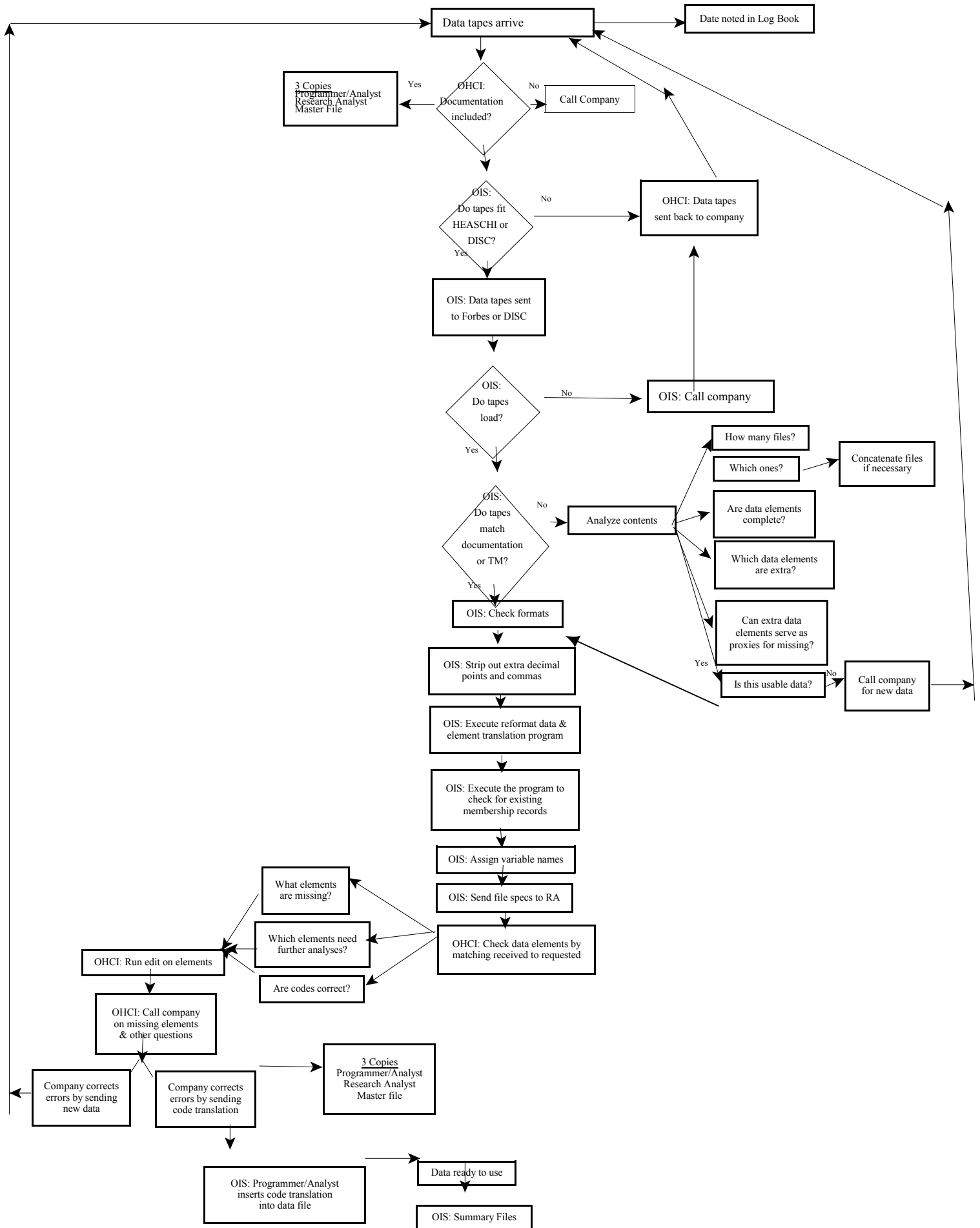
cc: Karen Brodsky, Stephen Somers, Scott Simerly

Appendix E

Data Process

Insurance Stat Plan

Data Receipt Process



Appendix F

Proposed Standard Reports

Plan Type:
 Policy Form or Plan Name:
 Report Period:
 Deductible:

Payer:
 Area:
 Other: (free form, e.g. age, sex)
 Coinsurance:

		Amount Charged	Amount Allowed	Amount Paid	Allowed/ Charged	Paid/ Charged	Paid/ Allowed
Category	Subcategory						
INSTITUTION	Inpatient	Surgery	12,331	11,787	9,878	95.6%	83.8%
		ICU\CCU	5,552	4,444	4,400	80.0%	99.0%
		Maternity	2,989	2,675	2,544	89.5%	95.1%
		Psych\Sub Abuse	1,978	1,502	890	75.9%	59.3%
		Other	6,120	5,644	5,590	92.2%	99.0%
	Subtotal		28,970	26,052	23,302	89.9%	89.4%
	Outpatient	Emergency Room	4,121	4,040	4,004	98.0%	99.1%
		Outpat Surgery	6,989	6,675	6,007	95.5%	90.0%
		Diag X-ray/Lab	6,303	5,734	5,570	91.0%	97.1%
		Psych\Sub Abuse	404	206	134	51.0%	65.0%
		Subtotal	17,817	16,655	15,715	93.5%	94.4%
	Skilled Nursing Facility		678	657	600	96.9%	91.3%
	Home Health		1,434	1,256	1,100	87.6%	87.6%
	Substance Abuse Treatment Center		1,566	980	400	62.6%	40.8%
	Dialysis Center		300	300	240	100.0%	80.0%
	TOTAL		50,765	45,900	41,357	90.4%	90.1%
PHYSICIAN	Primary Care	Patient Visits	10,134	9,898	8,909	97.7%	90.0%
		Immun & Injection	1,265	1,183	1,001	93.5%	84.6%
		Subtotal	11,399	11,081	9,910	97.2%	89.4%
	Specialty Care	Surgery-Inpatient	5,676	5,159	4,236	90.9%	82.1%
		Surgery-Outpatient	8,536	8,500	8,123	99.6%	95.6%
		Surgery-Office	3,452	3,378	2,874	97.9%	85.1%
		Inpatient Visits	1,178	1,170	1,089	99.3%	93.1%
		Psych\Sub Abuse	3,056	2,200	1,236	72.0%	56.2%
		Maternity-Normal Del	2,689	2,609	2,458	97.0%	94.2%
		Maternity-C-Section	1,989	1,876	1,607	94.3%	85.7%
		Maternity Other	1,016	980	926	96.5%	94.5%
		Anesthesia	4,486	4,340	3,987	96.7%	91.9%
		Patient visit& spec test	3,576	3,455	3,260	96.6%	94.4%
		Consultations	1,030	1,030	880	100.0%	85.4%
		Emergency Services	1,462	1,398	1,191	95.6%	85.2%
		Subtotal	38,146	36,095	31,867	94.6%	88.3%
	TOTAL		49,545	47,176	41,777	95.2%	88.6%
DIAG X-RAY & LAB	X-Ray		765	703	599	91.9%	85.2%
	Lab		2,176	1,985	1,612	91.2%	81.2%
	TOTAL		2,941	2,688	2,211	91.4%	82.3%
MISCELLANEOUS	Ambulance		1,452	1,301	1,101	89.6%	84.6%
	Radiation Therapy		1,353	1,206	988	89.1%	81.9%
	Chemotherapy		465	465	405	100.0%	87.1%
	Phys Therapy		526	504	409	95.8%	81.2%
	Speech Therapy		255	255	207	100.0%	81.2%
	Occup Therapy		534	484	390	90.6%	80.6%
	Chiropractic		450	400	202	88.9%	50.5%
	Hospice		650	550	505	84.6%	91.8%
	Durable Med Equipment		3,675	3,567	3,076	97.1%	86.2%
	Preventive Care		6,780	5,698	3,244	84.0%	56.9%
	Prescription Drugs		21,348	17,569	7,533	82.3%	42.9%
	Vision and Ear		6,755	5,567	1,132	82.4%	20.3%
	All Other		189	133	106	70.4%	79.7%
	TOTAL		44,432	37,699	19,298	84.8%	51.2%
GRAND TOTALS			147,683	133,463	104,643	90.4%	78.4%

Healthcare Costs Trends Report - Cost per Unit

Plan Type:

Payer:

Policy Form or Plan Name:

Area:

Report Period:

Other: (free form)

	Category	Subcategory	Current	Previous	Annualized	Previous	
			Actual	Quarter	Change	Year	Change
				Actual		Actual	
INSTITUTION	Inpatient	Surgery	\$1,334	\$1,279	17.2%	\$1,211	10.2%
		ICU\CCU	2,765	2,691	11.0%	2,600	6.3%
		Maternity	1,211	1,200	3.7%	1,144	5.9%
		Psych\Sub Abuse	498	501	-2.4%	490	1.6%
		Other	1,066	978	36.0%	1,050	1.5%
		TOTAL	1,305	1,288	5.3%	1,274	2.4%
	Outpatient	Emergency Room	304	300	5.3%	300	1.3%
		Outpat Surgery	1,045	1,106	-22.1%	1,003	4.2%
		Diag X-Ray\Lab	299	286	18.2%	280	6.8%
		Psych\Sub Abuse	194	190	8.4%	175	10.9%
	Skilled Nursing Facility		77	76	5.3%	73	5.5%
	Home Health		45	45	0.0%	45	0.0%
	Substance Abuse Treatment Center		101	100	4.0%	90	12.2%
	Dialysis Center		56	55	7.3%	50	12.0%
PHYSICIAN	Primary Care	Patient Visits	44	45	-8.9%	45	-2.2%
		Immun & Injection	25	25	0.0%	25	0.0%
	Speciality Care	Surgery-Inpatient	2,564	2,469	15.4%	2,469	3.8%
		Surgery-Outpatient	922	909	8.6%	884	4.3%
		Surgery-Office	106	104	7.7%	99	7.1%
		Inpatient Visits	84	85	-4.7%	75	12.0%
		Psych\Sub Abuse	77	77	0.0%	75	2.7%
		Maternity-Normal Del	1,342	1,300	12.9%	1,250	7.4%
		Maternity-C-Section	2,545	2,502	6.9%	2,500	1.8%
		Maternity-Other	344	345	-1.2%	340	1.2%
		Anesthesia	407	400	7.0%	400	1.8%
		Patient visit & spec tests	65	65	0.0%	65	0.0%
		Consultations	111	110	3.6%	110	0.9%
		Emergency Services	98	97	4.1%	90	8.9%
DIAG X-RAY	X-Ray		64	60	26.7%	60	6.7%
	Lab		33	33	0.0%	30	10.0%
MISCELLANEOUS	Ambulance		645	645	0.0%	640	0.8%
	Radiation Therapy		234	230	7.0%	220	6.4%
	Chemotherapy		95	96	-4.2%	90	5.6%
	Phys Therapy		25	25	0.0%	25	0.0%
	Speech Therapy		37	35	22.9%	30	23.3%
	Occup Therapy		30	30	0.0%	30	0.0%
	Chiropractic		46	45	8.9%	45	2.2%
	Hospice		552	525	20.6%	500	10.4%
	Durable Med Equipment		304	300	5.3%	300	1.3%
	Preventive Care		156	155	2.6%	155	0.6%
	Prescription Drugs		24	25	-16.0%	25	-4.0%
	Vision and Ear		112	110	7.3%	100	12.0%
	All Other		676	659	10.3%	651	3.8%

PMPM Comparison to Standards Report

Plan Type:

Payer:

Policy Form or Plan Name:

Area:

Report Period:

Other: (free form)

Category		Subcategory	PMPM Actual	PMPM Expected	Ratio A\E	
INSTITUTION	Inpatient	Surgery	\$12.06	\$11.17	108.0%	
		ICU\CCU	5.05	4.33	116.6%	
		Maternity	3.07	2.99	102.7%	
		Psych\Sub Abuse	1.54	1.76	87.5%	
		Other	6.34	6.50	97.5%	
		Subtotal	\$28.06	\$26.75	104.9%	
	Outpatient	Emergency Room	4.14	4.00	103.5%	
		Outpat Surgery	7.39	7.70	96.0%	
		Diag X-ray\Lab	5.87	5.25	111.8%	
		Psych\Sub Abuse	0.40	0.40	100.0%	
		Subtotal	\$45.86	\$44.10	104.0%	
	Skilled Nursing Facility	0.43	0.55	78.2%		
	Home Health	0.61	0.60	101.7%		
	Substance Abuse Treatment Center	0.44	0.39	112.8%		
	Dialysis Center	0.06	0.10	60.0%		
	TOTAL		\$75.46	\$72.49	104.1%	
	PHYSICIAN	Primary Care	Patient Visits	10.25	10.50	97.6%
			Immun & Injection	0.65	0.50	130.0%
			Subtotal	\$10.90	\$11.00	99.1%
Specialty Care		Surgery-Inpatient	4.98	5.09	97.8%	
		Surgery-Outpatient	7.88	7.67	102.7%	
		Surgery-Office	3.44	3.70	93.0%	
		Inpatient Visits	0.51	0.55	92.7%	
		Psych\Sub Abuse	1.99	1.88	105.9%	
		Maternity-Normal Del	1.66	1.60	103.8%	
		Maternity-C-Section	1.49	1.55	96.1%	
		Maternity-Other	0.57	0.55	103.6%	
		Anesthesia	4.04	3.90	103.6%	
		Patient visit & spec test	3.27	3.30	99.1%	
		Consultations	0.68	0.60	113.3%	
		Emergency Services	0.59	0.55	107.3%	
		Subtotal	\$31.10	\$30.94	100.5%	
		TOTAL	\$42.00	\$41.94	100.1%	
DIAG X-RAY & LAB		X-Ray	0.45	0.45	100.0%	
		Lab	1.53	1.35	113.3%	
		TOTAL	\$1.98	\$1.80	110.0%	
MISCELLANEOUS		Ambulance	0.57	0.70	81.4%	
		Radiation Therapy	0.63	0.60	105.0%	
		Chemotherapy	0.12	0.10	120.0%	
		Phys Therapy	0.40	0.25	160.0%	
		Speech Therapy	0.11	0.13	84.6%	
		Occup Therapy	0.35	0.29	120.7%	
		Chiropractic	0.26	0.27	96.3%	
		Hospice	0.23	0.20	115.0%	
		Durable Med Equipment	2.68	2.60	103.1%	
		Preventive Care	5.87	7.00	83.9%	
		Prescription Drugs	21.00	17.95	117.0%	
		Vision and Ear	4.86	5.25	92.6%	
		All Other	0.19	0.25	76.0%	
		TOTAL	\$37.27	\$35.59	104.7%	
		GRAND TOTALS		156.71	\$151.82	103.2%

Healthcare Cost Per Unit Comparison to Standards Report

Plan Type:

Payer:

Policy Form or Plan Name:

Area:

Report Period:

Other: (free form)

	Category	Subcategory	Cost per Unit		Ratio A/E
			Actual	Expected	
INSTITUTION	Inpatient	Surgery-Office	\$1,334	\$1,400	95.3%
		ICU\CCU	2,765	2,600	106.3%
		Maternity	1,211	1,200	100.9%
		Psych\Sub Abuse	498	500	99.6%
		Other	1,066	1,050	101.5%
		TOTAL	1,305	1,320	98.9%
	Outpatient	Emergency Room	304	300	101.3%
		Outpat Surgery	1,045	1,100	95.0%
		Diag X-ray\Lab	299	280	106.8%
		Psych\Sub Abuse	194	200	97.0%
	Skilled Nursing Facility		77	80	96.3%
	Home Health		45	50	90.0%
	Substance Abuse Treatment Center		101	90	112.2%
	Dialysis Center		56	60	93.3%
PHYSICIAN	Primary Care	Patient Visits	44	45	97.8%
		Immun & Injection	25	25	100.0%
	Speciality Care	Surgery-Inpatient	2,564	2,469	103.8%
		Surgery-Outpatient	922	909	101.4%
		Surgery-Office	106	104	101.9%
		Inpatient Visits	84	75	112.0%
		Psych\Sub Abuse	77	80	96.3%
		Maternity-Normal Del	1,342	1,300	103.2%
		Maternity-C Section	2,545	2,500	101.8%
		Maternity-Other	344	365	94.2%
		Anesthesia	407	400	101.8%
		Patent visit & spec tests	65	70	92.9%
		Consultations	111	120	92.5%
		Emergency Services	98	100	98.0%
DIAG X-RAY & LAB		X-Ray	64	60	106.7%
		Lab	33	30	110.0%
MISCELLANEOUS		Ambulance	645	700	92.1%
		Radiation Therapy	234	250	93.6%
		Chemotherapy	95	100	95.0%
		Phys Therapy	25	25	100.0%
		Speech Therapy	37	40	92.5%
		Occup Therapy	30	30	100.0%
		Chiropractic	46	50	92.0%
		Hospice	552	500	110.4%
		Durable Med Equipment	304	300	101.3%
		Preventive Care	156	175	89.1%
		Prescription Drugs	24	25	96.0%
		Vision and Ear	112	100	112.0%
		All Other	676	700	96.6%

Utilization Comparison to Standards Report

Plan Type:

Payer:

Policy Form or Plan Name:

Area:

Report Period:

Other: (free form)

	Category	Subcategory	Rates per Thousand		Ratio A\E
			Actual	Expected	
INSTITUTION	Inpatient	Surgery	77	80	96.3%
		ICU\CCU	27	22	122.7%
		Maternity	31	34	91.2%
		Psych\Sub Abuse	42	40	105.0%
		Other	87	85	102.4%
		TOTAL	264	261	101.1%
	Outpatient	Emergency Room	166	165	100.6%
		Outpat Surgery	93	100	93.0%
		Diag X-ray Lab	308	300	102.7%
		Psych\Sub Abuse	23	20	115.0%
	Skilled Nursing Facility		111	120	92.5%
	Home Health		240	220	109.1%
	Substance Abuse Treatment Center		62	50	124.0%
	Dialysis Center		2	2	100.0%
PHYSICIAN	Primary Care	Patient Visits	2,398	2,400	99.9%
		Immun & Injection	188	180	104.4%
	Specialty Care	Surgery-Inpatient	26	30	86.7%
		Surgery- Outpatient	99	95	104.2%
		Surgery-Office	416	400	104.0%
		Inpatient Visits	77	80	96.3%
		Psych\Sub Abuse	287	270	106.3%
		Maternity-Normal Del	54	56	96.4%
		Maternity-C-Section	15	14	107.1%
		Maternity-Other	77	75	102.7%
		Anesthesia	332	350	94.9%
		Patient visit & spec tests	77	70	110.0%
		Consultations	103	100	103.0%
		Emergency Services	106	100	106.0%
DIAG X - RAY & LAB		X-Ray	81	80	101.3%
		Lab	581	540	107.6%
MISCELLANEOUS		Ambulance	12	13	92.3%
		Radiation Therapy	31	29	106.9%
		Chemotherapy	9	7	128.6%
		Phys Therapy	116	120	96.7%
		Speech Therapy	36	40	90.0%
		Occup Therapy	133	120	110.8%
		Chiropractic	99	100	99.0%
		Hospice	2	4	50.0%
		Durable Med Equipment	92	100	92.0%
		Preventive Care	574	600	95.7%
		Prescription Drugs	5,452	5,000	190.0%
		Vision and Ear	666	650	102.5%
		All Other	4	5	80.0%

Comparison of Kansas Procedures Against National Norms form HIAA Data

Procedures	Bodily System	# of	Percent	Weighted	Percent of National	
		Charges	Total	Avg CF	Median	Average Median
10000-19499	Integumentary System	12,548,490	35.8%	104.2	94.5	100.0%
20000-29909	Musculosketelal System	4,546,490	13.0%	133.1	128.3	100.0%
30000-32999	Respiratory System	970,080	2.8%	143.5	132.8	100.0%
33010-37799	Cardiovascular System	5,913,262	16.9%	112.3	108.3	100.0%
38100-38999	Hemic & Lymphatic Systems	50,070	0.1%	140.4	131.4	100.0%
39000-39599	Mediastinum & Diaphragm	8,133	0.0%	140.5	131.2	100.0%
40490-49999	Digestive System	3,280,200	9.4%	116.4	112.4	100.0%
50010-53899	Urinary System	1,310,346	3.7%	96.8	93.8	100.0%
54000-55980	Male Genital System	602,666	1.7%	122	114.7	100.0%
56000-58999	Female Genital System	1,943,379	5.5%	137.4	128.3	100.0%
59000-59899	Maternity Care & Delivry	1,174,346	3.4%	112.9	102.5	100.0%
60000-60699	Endocrine System	39,880	0.1%	116.3	110.8	100.0%
61000-64999	Nervous System	937,635	2.7%	130.1	125.6	100.0%
65091-68899	Eye & Ocular Adnexa	1,115,466	3.2%	85.5	83.8	100.0%
69000-69979	Auditory System	575,732	1.6%	103.5	98.4	100.0%
	Area Total	35,016,175	100.0%	115.1	109.1	100.0%

Shawnee M.

Surgical

Procedures	Bodily System	# of	Percent	Weighted	Percent of National	
		Charges	Total	Avg CF	Median	Average Median
10000-19499	Integumentary System	22,748	31.9%	106.8	103.5	102.5%
20000-29909	Musculosketelal System	8,423	11.8%	121.3	121.6	91.1%
30000-32999	Respiratory System	1,547	2.2%	149.9	145.6	104.5%
33010-37799	Cardiovascular System	11,762	16.5%	101.6	103.6	90.5%
38100-38999	Hemic & Lymphatic System	75	0.1%			
39000-39599	Mediastinum & Diaphragm	12	0.0%			
40490-49999	Digestive System	6,676	9.4%	104.0	98.9	89.3%
50010-53899	Urinary System	2,375	3.3%	88.8	89.2	91.7%
54000-55980	Male Genital System	1,922	2.7%	107.6	104.7	88.2%
56000-58999	Female Genital System	6,378	8.9%	127.6	126.9	92.9%
59000-59899	Maternity Care & Delivery	4,411	6.2%	103.2	100.8	91.4%
60000-60699	Endocrine System	40	0.1%			
61000-64999	Nervous System	2,385	3.3%	120.0	118.3	82.2%
65091-68899	Eye & Ocular Adnexa	1,383	1.9%	84.8	89.6	99.2%
69000-69979	Auditory System	1,135	1.6%	97.9	89.6	94.6%
	Area Total	71,272	100.0%	109.3	107.9	95.0%

Rural Kansas

Surgical

Procedures	Bodily System	# of	Percent	Weighted	Percent of National	
		Charges	Total	Avg CF	Median	Average Median
10000-19499	Integumentary System	10,015	33.4%	89.0	87.3	85.4%
20000-29909	Musculosketelal System	2,974	9.9%			
30000-32999	Respiratory System	420	1.4%			
33010-37799	Cardiovascular System	7,810	26.0%			
38100-38999	Hemic & Lymphatic Systems	13	0.0%			
39000-39599	Mediastinum & Diaphragm		0.0%			
40490-49999	Digestive System	2,151	7.2%	99.6	100.0	85.6%
50010-53899	Urinary System	963	3.2%	75.8	73.0	78.3%
54000-55980	Male Genital System	629	2.1%	88.3	89.7	72.4%
56000-58999	Female Genital System	1,987	6.6%	94.1	97.3	68.5%
59000-59899	Maternity Care & Delivery	1,251	4.2%	85.4	85.5	75.6%
60000-60699	Endocrine System	21	0.1%			
61000-64999	Nervous System	392	1.3%			
65091-68899	Eye & Ocular Adnexa	701	2.3%	69.1	66.3	80.8%
69000-69979	Auditory System	670	2.2%	96.9	98.4	93.6%
	Area Total	29,997	100.0%	90.4	90.7	78.5%

Member Module

Data Record Layout

Appendix F

It is proposed that the KDHE receive member records from each player in the recommended format.

Information in this module can then be linked to the information in the Utilization Module by the Payer, Policy, and Member I.D. fields.

Information in this module can also be linked to a Payer module, if developed, in conjunction with the Utilization Module to identify and analyse encounter level data for specific policy forms.

Element	Format	Coding
Payer Start of Reporting Period End of Reporting Period Eligible Months in Reporting Period	4N Date Date 2N	NAIC Number May include up to 12 mos. for low volume payers. Normally will be 01-03.
Member ID Pat SSN* Pat DOB* Pat Sex* *All three items are components in I.D. encryption Resident Zipcode Resident County Member Status	4N Date 1N 5N 2A 1N	Last 4 digits SSN Male = 1, Female = 2 1=Active Insured, 2=Spouse, 3=Dependent
Policy Form Number Monthly Premium Deductible Coinsurance Plan Type**	7N 6N 1N 1N 1N	Policy Number 9999.99 1= 0-499, 2= 500-999, 3= 1000+ 1=81%=, 2= 80%, 3=51-79%, 4=50% or less Indemnity, PPO, HMO, POS

** Plan type is not needed as an element in the Member data file if the KDHE implements the Policy Table in the proposed Plan Module.

Utilization Module

Master Data Record Layout

Appendix F

It is proposed that the KDHE receive claims records from each payer in the National Standard ANSI X.12 837 format. Data would then be moved into a single flat file record, as proposed below, to facilitate analysis and reporting. All claim types would be kept together, with common data stored to the same location in the record. Depending on database capabilities, KDHE may wish to use “redefines” of storage locations in order to conserve storage. For example, the pharmacy claim NDC can extend into the area that would be used for “modifier” and Place of service on practitioner claims.

Practitioner (physicians and other HCFA 1500 billers), hospital outpatient, and pharmacy claims with multiple service line items would be made into multiple records in the KDHE data base. Other claim types would be stored as only a single record for the entire claim. The increment number field would allow KDHE to avoid double counting Total amounts in reporting and queries.

Element	Format	Hospital Inpatient	Hospital Outpat/Dialysis	Nursing Facility/Hospice	Home Health Agency	Practitioner & Other	Dental	Pharmacy
Payer (NAIC NO.)	4N	X	X	X	X	X	X	X
Policy Form Number	7A	X	X	X	X	X	X	X
Member ID								
Pat SSN*	Last 4 digits SSN	X	X	X	X	X	X	X
Pat DOB*	Date**	X	X	X	X	X	X	X
Pat Sex*	1N	X	X	X	X	X	X	X
*All three items are components in I.D. encryption								
Service/Provider Type	2A	See Utilization Module Data Coding Table						
Provider Number	10A	Medicare	Medicare	Payer's ID	Payer's ID	Payer's ID	Payer's ID	Payer's ID
Provider Location	5N	X	X	X	X	X	X	X
Provider Specialty	2A	X	X	X	X	X	X	X
First Date of Service	Date**	Adm Date	X	Adm Date	X	X	X	Disp Date
Last Date of Service	Date**	Disch Date	X	Disch Date	X	X	X	-
Date Paid/Adjudicated	Date**	X	X	X	X	X	X	X
Primary Diagnosis	5A	X	X	X	X	X		
Second Diagnosis	5A	X	X					
Third Diagnosis	5A	X	X					
Discharge Status	2A	X						
Procedure Code	5A/13A	ICD-9-CM	CPT , when avail			HCPCS	ADA	NDC
Modifier	2A					X	X	
Place of Service	2N					X		
Units of Service	2N	Total Days		Total Days	Visits	X	X	X
Therapeutic Class Code	8N						X	
Brand Name	1N						X	
Increment/Line Item No.	1N		X			X	X	X
Total Charge	10.2N	X	X	X	X	X	X	X
Total Allowed	10.2N	X	X	X	X	X	X	X
Total Paid	10.2N	X	X	X	X	X	X	X
Line Item Charge	8.2N		X			X	X	X
Line Item Allowed	8.2N		X			X	X	X
Line Item Paid	8.2N		X			X	X	X
Attending/Prescribing Provider	10A	Payer's ID	Payer's ID		Payer's ID	Payer's ID		Payer's ID
Service Category	3A	Assigned by KDHE from Criteria Table						

**Dates are to be coded “YYYYMMDD” or “MM/DD/YYYY” depending on the database software used by KDHE.

Plan Module

Master Data Record Layout

Appendix F

This module consists of two cross-reference tables maintained by KDHE:

The first table, Payer Information, is used to retrieve name and address information, when needed for reports (note that the utilization module will only carry the NAIC number.)

The second table, the “Policy Table,” is used to cross-reference policy numbers from the utilization module to plan characteristics. As deductibles, co-pays, and other plan characteristics are difficult to categorize, this table should allow for detailed information to be entered in a free-form text field. This will allow analysts to categorize on an as-needed basis for specific analyses.

Payer Information Table

Element	Format	Coding
Payer Number	4N	NAIC Number
Payer Name	50A	
Address Information		
Street Address	75A	
City	25A	
State	2A	
Zipcode	5N	
Payer Type	1A	Association, Commercial, Blue Cross, HMO, Self-Insured
Date of Last Data Submission (i.e., covers services paid through this date.)	Date	
Date Last Data Submission Received	Date	

Policy Table

Element	Format	Coding
Payer Number	4N	NAIC Number
Policy Number	7N	
		Payer’s Internal Number-Should Correspond to Policy Nos. in Utilization and Member modules.
Plan Type:	1N	Indemnity, PPO, HMO, POS
Maximum Indiv. Deductible	1N	1= 0-499, 2= 500-999, 3= 1000+
Coinsurance Percent	1N	1= 81%+, 2= 80%, 3= 51-79%, 4= 50% or less
Medical Copay	1N	1= 0-9, 2= 10-14, 3= 15-24, 4= 25+
Other Benefit Features	1N	1= 0-5, 2= 6-14, 3= 15+, 4= Other
		Allow for free form text

Utilization Module

Data Coding

Appendix F

Element	Coding
Service/Provider Type Key	C Outpatient Clinic E Emergency Department H Home Health Agency I Hospital Inpatient N Dental O All Other X Diagnostic X-Ray AM Ambulance CH Chiropractor CT Chemotherapy DM Durable Medical Equipment HS Hospice KD Dialysis IL Laboratory MD Practitioner OC Occupational Therapy PC Preventive Care PT Physical Therapy RT Radiation Therapy RX Pharmacy/Prescription SN Nursing Facility ST Speech Therapy VE Vision and Ear
Provider Number	Will use Medicare numbers for hospitals; numbers will assigned by payers for other providers
Provider Location	Primary practice site zipcode
First Date of Service	First date of outpatient service identified on claim or encounter, or inpatient date of admission
Last Date of Service	Inpatient: Leave blank if not discharged at end of reporting period
Date Paid/Adjudicated	
Primary Diagnosis	Left justified, no decimal point ICD-9-CM code. For inpatient, use discharge diagnosis
Secondary Diagnosis	Same as above
Third Diagnosis	Same as above
Discharge Status	UB-92 codes. Should show "30" for patients not discharged at end of reporting period
Procedure Code	Left justified, CPT-4, ICD-9, or HCPC codes, NDC codes for Pharmacy
Modifier	Left justified procedure modifier, if present
Place of Service	HCFA 1500 instructions
Units of Service	Report days for inpatient services, and service units for other claim types
Therapeutic Class Code	To be assigned by payer or drug plan
Brand Name	1= Brand name, 2= Generic
Increment/Line Item No.	Procedure line number from claim or encounter form (01 - 35)
Total Charge	Charge per claim form
Total Allowed	Charges allowed by insurer per claim form
Total Paid	Total paid by insurer per claim form
Line Item Charge	
Line Item Allowed	
Line Item Paid	
Attending/Prescribing Provider	Provider ID number, may be encrypted by payer
Specialty	Provider specialty code, per ANSI x .12

Selection Criteria for Claim Expense Types

	Service Category	Category	Subcategory	Service/ Provider Type	Criteria			
I N S U R I O N	110	Inpatient	Surgery	I	Revenue Codes =	360 - 369 present on claim	or identified by payer	
	120		ICU/CCU	I	Revenue Codes=	200 - 219 present on claim	or identified by payer	
	130		Maternity	I	Primary Diagnosis =	630 - 676, V22 -V39		
	140		Psych/SubAbuse	I	Primary Diagnosis =	290 - 319		
	150		Other	I	Primary Diagnosis =	All other diagnosis codes		
	210	Outpatient	Emer Room	E	HCPCS =	99281 - 99288	or Revenue Codes =	450 -459
	220		Outpat Surgery	C	Revenue Codes =	490 - 499 present on line item	o r identified by payer	
	230		Diag X-ray/lab	C	Revenue Codes =	300 -329 present on line item	or identified by payer	
	240		Psych/SubAbuse	C	Primary Diagnosis =	290 - 319		
	250		Other	C	Primary Diagnosis =	All other diagnosis codes		
310	Skilled Nursing Facility		SN	HCPCS =	99301 - 99313			
320		Home Health	H					
340		Sub Abuse Treat Center	C					
350		Dialysis Center	KD	HCPCS =	90918 - 90999			
P H Y S I C I A N	410	Primary Care	Patient Visits	MD	HCPCS =	99201 - 99205, 99211 - 99205	and Place of Service =	11
	420		Immun & Inject	MD	HCPCS =	90700 - 90749		
	510	Specialty Care	Surgery-Inpatient	MD	HCPCS =	10040 - 69979	and Place of Service =	
	520		Surgery-Outpatient	MD		10040 - 69979		21
	530		Surgery-Office	MD		10040 - 69979		22, 24
	540		Inpatient Visits	MD	HCPCS =	99217 - 99238	and Place of Service =	11
	550		Psych/SubAbuse	MD	HCPCS =	99221 - 99233 (Inpatient & partial)		21
	560	Maternity-Norm Del		MD	HCPCS =	90801 - 90899		
	570		Maternity-C-Sect	MD	HCPCS =	59000 - 59430		
	580		Maternity-Other	MD	HCPCS =	59510 - 59525		
					Primary Diagnosis =	630 - 676, V22, V27	and Not Assigned to normal delivery or C-Section	
	590	Anesthesia		MD	HCPCS =	00100 - 01999		
	610		Pat Visit & Spec Tests	MD	HCPCS =	93000 - 93399		
	Cardiology				93555 - 93799			
	Allergy				95000 - 95099			
620	EEG, Sleep		MD	HCPCS =	95800 - 95999			
630		Consultations	MD	HCPCS =	99241 - 99275			
		Emergency Services	MD	HCPCS =	99058, 99281 - 99285	or Place of Service =	23	
D I A G	710	X-Ray Lab		MD, X	HCPCS =	70010 -76999, 77600 - 7999		
	720			MD, IL	HCPCS =	80002 - 89399		
M I S C E L L A N E O U S	810	Ambulance		AM				
	850		Radiation Therapy	MD, RT	HCPCS =	77261 - 77499		
	860		Chemotherapy	MD, CT	HCPCS =	96400 - 96549		
	870		Physical Therarpy	MD, PT	HCPCS =	97010 - 97039, 97110 - 97799		
	880		Speech Therapy	MD, ST	HCPCS =	92502 - 92599		
	890		Occupational Therapy	MD, CC				
	910		Chiropractic	CH				
	920		Hospice	HS				
	930		Durable Med Equipment	DM				
	940		Preventive Care	PC	HCPCS =	99381 - 99429		
950	Prescription Drugs	RX						
960		Vision and Ear	VE	HCPCS =	92002 - 92499, 92551 - 92599			
970		Dental	N					
	990	All Other	O	All services not fitting criteria for categories 110 - 990				
		Total						

Appendix G

Benefit Ratio Report

BENEFIT RATIO REPORT

15:09 Monday, June 15, 1998

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 0

COINSURANCES: Facility - 0 Professional - 0 Combined - 0.5 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'Y'

LINE OF BUSINESS	CATEGORY	SUBCATEGORY	TOTAL CHARGE	ALLOWED CHARGE	PAID CHARGE	ALLOWED TO TOTAL	PAID TO TOTAL	PAID TO ALLOWED
A - INSTITUTION	INPATIENT	ICU/CCU	46877	34225	34225	73.0	73.0	100.0
		MATERNITY	3333	2462	2462	73.9	73.9	100.0
		OTHER INPATIENT	13580	11700	9523	86.2	70.1	81.4
		SURGERY	24830	19314	19314	77.8	77.8	100.0
A - INSTITUTION	INPATIENT		88619	67701	65524	76.4	73.9	96.8
	OUTPATIENT	DIAG XRAY/LAB	30539	27935	19574	91.5	64.1	70.1
		OTHER OUTPATIENT	44539	27296	21432	61.3	48.1	78.5
		OUTPATIENT SURGERY	1329	1130	799	85.0	60.1	70.7
		PSYCH/SUB ABUSE	290	234	126	80.7	43.4	53.8
A - INSTITUTION	OUTPATIENT		76697	56595	41931	73.8	54.7	74.1
A - INSTITUTION			165316	124296	107454	75.2	65.0	86.4
B - PHYSICIAN	PRIMARY CARE	IMMUNIZATION & INJECTIONS	2213	1803	1265	81.5	57.2	70.2
		PATIENT VISITS	45214	39906	23633	88.3	52.3	59.2
B - PHYSICIAN	PRIMARY CARE		47427	41708	24898	87.9	52.5	59.7
	SPECIALTY CARE	CONSULTATIONS						
		EEG, SLEEP	3109	2877	2055	92.5	66.1	71.4
		EMERGENCY SERVICES	4028	2265	1846	56.2	45.8	81.5
		INPATIENT VISITS	52533	46313	34790	88.2	66.2	75.1
		MATERNITY-OTHER	2586	2288	2019	88.5	78.1	88.3
		PATIENT VISIT & SPECIAL TESTS	858	726	476	84.6	55.5	65.6
		PSYCH/SUB ABUSE	3888	3364	2521	86.5	64.8	74.9
		SURGERY-INPATIENT	4482	4336	2726	96.7	60.8	62.9
		SURGERY-OFFICE	24370	19483	17912	79.9	73.5	91.9
		SURGERY-OUTPATIENT	7051	6106	4835	86.6	68.6	79.2
			17490	13711	10623	78.4	60.7	77.5
B - PHYSICIAN	SPECIALTY CARE		120394	101469	79803	84.3	66.3	78.6
B - PHYSICIAN			167821	143177	104701	85.3	62.4	73.1
C - DIAGNOSTIC	LAB		4169	3338	1654	80.1	39.7	49.5
C - DIAGNOSTIC	LAB		4169	3338	1654	80.1	39.7	49.5

BENEFIT RATIO REPORT

15:09 Monday, June 15, 1998

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 0

COINSURANCES: Facility - 0 Professional - 0 Combined - 0.5 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'Y'

LINE OF BUSINESS	CATEGORY	SUBCATEGORY	TOTAL CHARGE	ALLOWED CHARGE	PAID CHARGE	ALLOWED TO TOTAL	PAID TO TOTAL	PAID TO ALLOWED
C - DIAGNOSTIC	XRAY		9701	7435	5323	76.6	54.9	71.6
C - DIAGNOSTIC	XRAY		9701	7435	5323	76.6	54.9	71.6
C - DIAGNOSTIC			13870	10774	6977	77.7	50.3	64.8
D - MISCELLANEOUS	PHYSICAL THERAPY		2078	1937	1053	93.2	50.7	54.4
D - MISCELLANEOUS	PHYSICAL THERAPY		2078	1937	1053	93.2	50.7	54.4
	PRESCRIPTION DRUG		10375	9138	6569	88.1	63.3	71.9
D - MISCELLANEOUS	PRESCRIPTION DRUG		10375	9138	6569	88.1	63.3	71.9
	SPEECH THERAPY		1667	1569	1021	94.2	61.3	65.1
D- MISCELLANEOUS	SPEECH THERAPY		1667	1569	1021	94.2	61.3	65.1
	VISION & EAR		2807	2311	1622	82.3	57.8	70.2
D - MISCELLANEOUS	VISION & EAR		2807	2311	1622	82.3	57.8	70.2
D - MISCELLANEOUS			16926	14955	10265	88.4	60.6	68.6
			=====	=====	=====	=====	=====	=====
			363934	293202	229397	80.6	63.0	78.2

BENEFIT RATIO REPORT

15:09 Monday, June 15, 1998

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 0

COINSURANCES: Facility - 0 Professional - 0 Combined - 0 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'Y'

LINE OF BUSINESS	CATEGORY	SUBCATEGORY	TOTAL CHARGE	PAID CHARGE	PAID TO TOTAL
A - INSTITUTION	INPATIENT	ICU/CCU	674787	130299	19.3
		MATERNITY	561373	191003	34.0
		OTHER INPATIENT	3547779	1013621	28.6
		PSYCH/SUB ABUSE	8411	4039	48.0
		SURGERY	15390	3298	21.4
A - INSTITUTION	INPATIENT		4807739	1342260	27.9
	OUTPATIENT	DIAG XRAY/LAB	86805	53001	61.1
		OTHER OUTPATIENT	2275022	1072261	47.1
		OUTPATIENT SURGERY	295656	63229	21.4
		PSYCH/SUB ABUSE	16669	4803	28.8
A - INSTITUTION	OUTPATIENT		2674152	1193295	44.6
A - INSTITUTION			7481891	2535554	33.9
B - PHYSICIAN	PRIMARY CARE	IMMUNIZATIONS & INJECTIONS	10803	4891	45.3
		PATIENT VISITS	275726	80632	29.2
B - PHYSICIAN	PRIMARY CARE		286529	85523	29.8
	SPECIALTY CARE	ALLERGY	2581	1967	76.2
		ANESTHESIA	0	0	0.0
		CARDIOLOGY	186	0	0.0
		CONSULTATIONS	34935	23131	66.2
		EEG, SLEEP	10997	5248	47.7
		EMERGENCY SERVICES	96482	32075	33.2
		INPATIENT VISITS	0	0	
		MATERNITY-OTHER	18009	9246	51.3
		PATIENT VISITS & SPECIAL TESTS	51821	8809	17.0
		PSYCH/SUB ABUSE	2162	0	0.0
		SURGERY-OFFICE	78242	37313	47.7
		SURGERY-OUTPATIENT	2495	1109	44.5
B - PHYSICIAN	SPECIALTY CARE		297910	118898	39.9
B - PHYSICIAN			584439	204421	35.0

BENEFIT RATIO REPORT

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 0

COINSURANCES: Facility - 0 Professional - 0 Combined - 0 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'Y'

LINE OF BUSINESS C - DIAGNOSTIC	CATEGORY LAB	SUBCATEGORY	TOTAL CHARGE 7838	PAID CHARGE 3179	PAID TO TOTAL 40.6
C - DIAGNOSTIC	LAB		7838	3179	40.6
	XRAY		164554	28440	17.3
C - DIAGNOSTIC	XRAY		164554	28440	17.3
C - DIAGNOSTIC			172392	31620	18.3
D-MISCELLANEOUS	CHEMOTHERAPY		163	33	20.0
D - MISCELLANEOUS	CHEMOTHERAPY		163	33	20.0
	PHYSICAL THERAPY		2842	1327	46.7
D - MISCELLANEOUS	PHYSICAL THERAPY		2842	1327	46.7
	PRESCRIPTION DRUG		1196373	805282	67.3
D - MISCELLANEOUS	PRESCRIPTION DRUG		1196373	805282	67.3
	SPEECH THERAPY		2652	2285	86.2
D MISCELLANEOUS	SPEECH THERAPY		2652	2285	86.2
	VISION & EAR		8262	6528	79.0
D - MISCELLANEOUS	VISION & EAR		8262	6528	79.0
D - MISCELLANEOUS			1210292	815455	67.4
			=====	=====	=====
			9449014	3587050	38.0

BENEFIT RATIO REPORT

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 250

COINSURANCES: Facility - 0 Professional - 0 Combined - 0.5 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'Y'

LINE OF BUSINESS	CATEGORY	SUBCATEGORY	TOTAL CHARGE	PAID CHARGE	PAID TO TOTAL
A - INSTITUTION	INPATIENT	ICU/CCU	23297	1989	8.5
		MATERNITY	30033	9073	30.2
		OTHER INPATIENT	152707	44336	29.0
A - INSTITUTION	INPATIENT		206037	55399	26.9
	OUTPATIENT	DIAG XRAY/LAB	3131	1287	41.1
		OTHER OUTPATIENT	107593	38154	35.5
		OUTPATIENT SURGERY	10709	3055	28.5
A - INSTITUTION	OUTPATIENT		121433	42495	35.0
A - INSTITUTION			327470	97894	29.9
B - PHYSICIAN	PRIMARY CARE	IMMUNIZATIONS & INJECTIONS	201	78	39.0
		PATIENT VISITS	18501	6878	37.2
B - PHYSICIAN	PRIMARY CARE		18702	6956	37.2
	SPECIALTY CARE	ALLERGY	680	384	56.5
		CONSULTATIONS	4013	2020	50.3
		EEG, SLEEP	995	464	46.7
		EMERGENCY SERVICES	28419	8453	29.7
		MATERNITY-OTHER	870	382	43.9
		PATIENT VISIT & SPECIAL TESTS	1783	724	40.6
		PSYCH/SUB ABUSE	2551	1282	50.2
		SURGERY-OFFICE	6184	3597	58.2
B - PHYSICIAN	SPECIALITY CARE		45494	17306	38.0
B - PHYSICIAN			64196	24263	37.8
C - DIAGNOSTIC	LAB		2145	782	36.4
C - DIAGNOSTIC	LAB		2145	782	36.4
	XRAY		3601	1370	38.0
C - DIAGNOSTIC	XRAY		3601	1370	38.0

BENEFIT RATIO REPORT

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 0

COINSURANCES: Facility - 0 Professional - 0 Combined - 0.5 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'Y'

C - DIAGNOSTIC		5746	2152	37.4
D - MISCELLANEOUS	PHYSICAL THERAPY	5266	2676	50.8
D - MISCELLANEOUS	PHYSICAL THERAPY	5266	2676	50.8
	PRESCRIPTION DRUG	40676	21885	53.8
D - MISCELLANEOUS	PRESCRIPTION DRUG	40676	21885	53.8
	VISION & EAR	218	120	55.2
D - MISCELLANEOUS	VISION & EAR	218	120	55.2

BENEFIT RATIO REPORT

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 250

COINSURANCES: Facility - 0 Professional - 0 Combined - 0.5 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'Y'

LINE OF BUSINESS	CATEGORY	SUBCATEGORY	TOTAL CHARGE	PAID CHARGE	PAID TO TOTAL
<hr/>					
D - MISCELLANEOUS			46160	24681	53.5
			=====	=====	=====
			443572	148990	33.6

BENEFIT RATIO REPORT

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 200

COINSURANCES: Facility - 0 Professional - 0 Combined - 0 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'N'

LINE OF BUSINESS	CATEGORY	SUBCATEGORY	TOTAL CHARGE	PAID CHARGE	PAID TO TOTAL
A - INSTITUTION	INPATIENT	ICU/CCU	53505	32077	60.0
		MATERNITY	6742	2365	35.1
		OTHER INPATIENT	481586	287752	59.8
		PSYCH/SUB ABUSE	89959	47874	53.2
A - INSTITUTION	INPATIENT		631792	370069	58.6
	OUTPATIENT	DIAG XRAY/LAB	11241	7103	63.2
		OTHER OUTPATIENT	272528	145749	53.5
		OUTPATIENT SURGERY	25391	12049	47.5
		PSYCH/SUB ABUSE	16465	8884	54.0
A - INSTITUTION	OUTPATIENT		325626	173784	53.4
A - INSTITUTION			957417	543853	56.8
B - PHYSICIAN	PRIMARY CARE	IMMUNIZATION & INJECTIONS	615	289	47.0
		PATIENT VISITS	32594	17111	52.5
B - PHYSICIAN	PRIMARY CARE		33209	17400	52.4
	SPECIALTY CARE	CONSULTATIONS	4488	2387	53.2
		EEG, SLEEP	925	543	58.7
		EMERGENCY SERVICES	7782	3454	44.4
		MATERNITY-OTHER	1937	902	46.6
		PATIENT VISIT & SPECIAL TESTS	1629	389	23.9
		PSYCH/SUB ABUSE	12397	6524	52.6
		SURGERY-INPATIENT	214	107	50.0
		SURGERY-OFFICE	7110	3436	48.3
B - PHYSICIAN	SPECIALTY CARE		36482	17742	48.6
B - PHYSICIAN			69691	35142	50.4
C - DIAGNOSTIC	LAB		1541	555	36.0
C - DIAGNOSTIC	LAB		1541	555	36.0
	XRAY		6407	3139	49.0
C - DIAGNOSTIC	XRAY		6407	3139	49.0

BENEFIT RATIO REPORT

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 200

COINSURANCES: Facility - 0 Professional - 0 Combined - 0 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'N'

LINE OF BUSINESS	CATEGORY	SUBCATEGORY	TOTAL CHARGE	PAID CHARGE	PAID TO TOTAL
C - DIAGNOSTIC			7948	3694	46.5
D - MISCELLANEOUS	CHEMOTHERAPY		80	60	75.0
D - MISCELLANEOUS	CHEMOTHERAPY		80	60	75.0
	PHYSICAL THERAPY		5150	2759	53.6
D - MISCELLANEOUS	PHYSICAL THERAPY		5150	2759	53.6
	PRESCRIPTION DRUG		257206	181288	70.5

BENEFIT RATIO REPORT

PAYER:

REPORT PERIOD: 1996 to 19961231

DEDUCTIBLES: Facility-0 Professional - 0 Combined - 0 Other - 200

COINSURANCES: Facility - 0 Professional - 0 Combined - 0 Other - 0

DENTAL COVERAGE: 'N' DRUG COVERAGE: 'N'

LINE OF BUSINESS	CATEGORY	SUBCATEGORY	TOTAL CHARGE	PAID CHARGE	PAID TO TOTAL
D - MISCELLANEOUS	PRESCRIPTION DRUG		257206	181288	70.5
D - MISCELLANEOUS	VISION & EAR		1516	1029	67.8
D - MISCELLANEOUS	VISION & EAR		1516	1029	67.8
D - MISCELLANEOUS			263952	185136	70.1
			1299009	767824	59.1

Appendix H

CHAMP National Database Tables

Table A.5
Utilization - By Type of Service and Beneficiary

	Utilization Per 1,000 Enrollees			
	<u>Total</u>	<u>Employees</u>	<u>Spouses</u>	<u>Children</u>
Inpatient Hospital Total - Days of Care	737	1,058	625	124
Medical	482	707	386	74
Surgical	200	287	182	18
Maternity	12	12	20	4
Mental Health	36	44	31	24
Chemical Dependency	6	7	6	4
Inpatient Hospital Total - Admissions	126	170	122	28
Medical	86	121	76	17
Surgical	31	40	33	5
Maternity	5	5	9	2
Mental Health	4	4	4	3
Chemical Dependency	1	1	1	1
Inpatient Hospital Total - ALOS	5.83	6.21	5.14	4.51
Medical	5.60	5.86	5.10	4.32
Surgical	6.53	7.11	5.57	3.81
Maternity	2.34	2.53	2.21	2.13
Mental Health	9.98	11.43	8.80	7.56
Chemical Dependency	7.47	7.47	7.53	7.36

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97.
Enrollment: Enrollees - 182,196 Employees - 91,353 Spouses - 52,748 Children - 38,095
Note: Group 77 Composition: DI, DZ, DQ, D(D), D[D], MZ, MQ, M(M!,MR,M), M@, MS, M[M#, MT, M], R(R), R[R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%, >Q, >(,>,>[,>],~(-.
Created: 06/18/98 - 10:25. Expense & Utilization Monitoring Module. Session KANSEU1 (Session ID - AG). (Continued)

Table A.5 (Cont.)
Utilization - By Type of Service and Beneficiary

Utilization Per 1,000 Enrollees

	<u>Total</u>	<u>Employees</u>	<u>Spouses</u>	<u>Children</u>
Inpatient Physician	1,409	1,991	1,266	212
Total - Units of Service				
Medical	1,249	1,777	1,119	164
Surgical	107	152	99	13
Maternity	5	5	9	2
Mental Health	45	54	38	32
Chemical Dependency	3	4	2	1
Outpatient Physician	8,547	9,682	9,142	5,001
Total - Units of Service				
Medical	7,939	8,989	8,531	4,601
Surgical	263	339	278	60
Mental Health	340	349	330	334
Chemical Dependency	5	5	3	6
Outpatient Misc.	15,695	17,560	19,924	5,367
Total - Units of Service				
Prescription Drugs	7,398	7,963	10,547	1,683
X-ray	1,052	1,223	1,262	353
HOPD - NOS	1,000	1,186	994	560
Medical Supplies	860	1,086	818	378
Laboratory	2,854	3,032	3,561	1,448
OP Surgery Facility	84	96	96	39
Unspecified	508	670	462	183
Physical Therapy	597	654	735	269
Other Specified	1,341	1,649	1,449	453
Hospital OP Dept.	3,427	3,944	3,803	1,657

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97.
 Enrollment: Enrollees - 182,196 Employees - 91,353 Spouses - 52,748 Children - 38,095
 Note: Units of service represent values as recorded by the claims payer. Hospital Outpatient Dept. is a subtotal of outpatient miscellaneous services delivered in hospital outpatient departments. Group 77 Composition: DI, DZ, DQ, D(D), D[D], MZ, MQ, M(M!,MR,M), M@, MS, M[M#, MT, M], R(R), R[R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%, >Q, >(,>,>[,>],~(.
 Create: 06/18/98 - 10:25. Expense & Utilization Monitoring Module. Session KANSEU1 (Session ID - AG).

Table A.6
Utilization - By Type of Service and Beneficiary

	<u>Total</u>	<u>Employees</u>	<u>Spouse</u>	<u>Children</u>
Inpatient Hospital		N.M.	N.M.	N.M.
Total - Expense Per Day	\$1,888			
Medical	1,720	1,729	1,727	1,481
Surgical	2,545	2,612	2,374	2,370
Maternity	1,413	N.M.	N.M.	N.M.
Mental Health	863	837	969	783
Chemical Dependency	651	592	877	477
Inpatient Hospital				
Total - Expense Per Admit	11,008	N.M.	N.M.	N.M.
Medical	9,642	10,139	8,800	6,394
Surgical	16,621	18,579	13,233	9,029
Maternity	3,310	N.M.	N.M.	N.M.
Mental Health	8,607	9,573	8,527	5,921
Chemical Dependency	4,860	4,418	6,596	3,513
Inpatient Physician				
Total - Expense Per Unit	177	N.M.	N.M.	N.M.
Medical	78	79	75	91
Surgical	1,260	1,231	1,347	1,153
Maternity	2,430	N.M.	N.M.	N.M.
Mental Health	75	72	76	88
Chemical Dependency	91	76	110	208

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97.
 Enrollment: Enrollees - 182,196 Employees - 91,353 Spouses - 52,748 Children - 38,095
 Note: Price is based on covered per unit of service. Prices by relation for maternity are not shown because expenses for normal newborns (DRG 391) are not billed consistently. Group 77 Composition: DI, DZ, DQ, D(.D), D[.D], MZ, MQ, M(.M), MR.M), M@, MS, M[.M#, MT, M], R(.R), R[.R], ZQ, Z(.ZR.Z) ZS, Z[.ZT.Z], %E, %I, %Z, %Q, %), %[.], >Q, >(.>), >[.], ~(.
 Created: 06/18/98 - 10:29. Expense & Utilization Monitoring Module. Session KANSEU1 (Sessions ID - AG). (Continued)

**Table A.6 (Cont.)
Price - By Type of Service and Beneficiary**

	<u>Total</u>	<u>Employees</u>	<u>Spouse</u>	<u>Children</u>
Outpatient Physician				
Total - Expense Per Unit	\$82	\$90	\$77	\$53
Medical	55	60	52	43
Surgical	881	907	850	735
Mental Health	75	75	74	75
Chemical Dependency	94	63	73	175
Outpatient Misc.				
Total	84	94	75	51
Prescription Drugs	51	53	50	32
X-ray	203	223	189	109
HOPD - NOS	214	243	212	67
Medical Supplies	99	107	98	51
Laboratory	29	32	27	22
OP Surgery Facility	948	982	943	768
Unspecified	127	137	118	71
Physical Therapy	76	88	65	50
Other Specified	115	130	95	77
Hospital OP Dept.	172	195	159	78

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97.
 Enrollment: Enrollees - 182,196 Employees - 91,353 Spouses - 52,748 Children - 38,095
 Note: Price is based on covered per unit of service. Hospital Outpatient Dept. is a subtotal of outpatient miscellaneous services delivered in hospital outpatient departments. Group 77 Composition: DI, DZ, DQ, D(D), D[,D], MZ, MQ, M(M!,MR,M), M@, MS, M[,M#, MT, M], R(R), R[,R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%], >Q, >(,>),>[,>],~(< 06/18/98 - 10:29. Expense & Utilization Monitoring Module. Session KANSEU1 (Session ID - AG).

Table B.3.1
Inpatient Physician - Utilization

	Unit of Service		Units of Service per 1,000 Enrollees	
	Year End		Annual Trend	
Inpatient Physician	06/97	Percent	Percent	Actual
Total	275,293	100%	-12%	1,511
Medical	227,622	83	-14	1,249
Visit & consultations	116,937	42	-13	642
Minor surgery codes	4,340	2	-12	24
X-ray/lab interpretations	63,339	23	-15	348
Diagnostic non-surg codes	19,078	7	-8	105
Therapeutic non-surg codes	1,349	0	-32	7
	22,579	8	-18	124
Surgical	29,093	11	-5	160
Surgery - diagnostic	9,018	3	-3	49
Surgery - therapeutic	10,522	4	-9	58
Surgery - NOS	23	0	15	0
Assistant surgeon	1,521	1	-11	8
Anesthesia	8,009	3	2	44
Maternity	9,978	4	2	55
Global C-sections	88	0	N.M.	0
Global vaginal deliveries	465	0	0	3
C-sections	1,049	0	-27	6
Vaginal deliveries	723	0	33	4
Diagnostic tests	572	0	-15	3
NOS	7,081	3	8	39
MH/CD	8,600	3	-15	47
Visits - psychiatric codes	2,688	1	0	15
Visits - non-psych codes	4,109	1	-21	23
Other - psychiatric	685	0	-2	4
Other - non-psych codes	1,118	0	-29	6

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
 Enrollment: Employees - 91,353 Enrollees - 182,196
 Note: Units of service represent values as recorded by the claims payor. Surgical units may not agree with surgical units in the presentation table which show one unit per procedure. Maternity units represent value recorded by the claims payor and may not agree with maternity units in the presentation tables which show number of admissions. Group 77 Composition: DI, DZ, DQ, D(D), D[D], MZ, MQ, M(M!,MR,M), M@, MS, M[,M#, MT, M], R(R), R[,R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%], >Q, >(,>),>[,>],~(.
 Created: 06/18/98 - 10:29. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

Table B.4.1
Inpatient Physician - Price

Inpatient Physician	Expense per Unit of Service	Annual Trend
	Year End 06/97	Percent
Total	\$165	9%
Medical	78	6
Visits & consultations	86	6
Minor surgery codes	213	6
X-ray/lab interpretations	48	4
Diagnostic non-surg codes	135	4
NOS	138	5
	46	1
Surgical	847	4
Surgery - diagnostic	308	-2
Surgery - therapeutic	1,554	10
Surgery - NOS	2,556	N.M.
Assistant surgeon	567	6
Anesthesia	574	-3
Maternity	236	-4
Global C-sections	1,822	N.M.
Global vaginal deliveries	1,507	-3
C-sections	153	37
Vaginal deliveries	612	-18
Diagnostic tests	84	-4
NOS	118	-8
MG/CD	76	-7
Visits - psychiatric codes	67	-25
Visits - non-psych codes	81	0
Other - psychiatric codes	92	-12
Other - non-psych codes	71	15

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
Enrollment: Employees - 91,353 Enrollees - 182,196
Note: Price is based on covered expense per unit of service. Group 77 Composition: DI, DZ, DQ, D(,D), D[,D], MZ, MQ, M(,M!,MR,M), M@, MS, M[,M#, MT, M], R(,R), R[,R], ZQ, Z(,ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%, >Q, >(,>),>[,>],~(.
Created: 06/18/98 - 10:30. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

CHAMP National Database - M9706
77 - Kansas Study, All Claimants

Table B.3.2
Outpatient Physician - Utilization

Outpatient Physician	Units of Service		Units of Service per 1,000 Enrollees	
	Year End 06/97	Percent 100%	Annual Trend Percent 8 %	Actual 8,653
Total	1,576,507			
Medical	1,446,394	92	9	7,939
Visits & consultations	714,115	45	6	3,919
Minor surgery codes	73,947	5	3	406
X-ray/lab interpretations	189,446	12	3	1,040
Diagnostic non-surg codes	92,414	6	-4	507
Therapeutic non-surg codes	8,361	1	1	46
NOS	368,111	23	22	2,020
Surgical	67,223	4	11	369
Surgery - diagnostic	16,571	1	12	91
Surgery - therapeutic	31,291	2	9	172
Surgery - NOS	52	0	N.M.	0
Assistant surgeon	912	0	19	5
Anesthetist	18,397	1	13	101
MH/CD	62,890	4	-3	345
Visit - psychiatric codes	39,226	2	-1	215
Visit - non-psych codes	12,594	1	1	69
Other - psychiatric codes	6,456	0	-22	35
Other - non-psych codes	4,614	0	-4	25

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
 Enrollment: Employees - 91,353 Enrollees - 182,196
 Note: Units of service represent values as recorded by the claims payor. Surgical units may not agree with surgical units in the presentation tables which show one unit per procedure.
 Group 77 Composition: DI, DZ, DQ, D(D), D[D], MZ, MQ, M(M!,MR,M), M@, MS, M[M#, MT, M], R(R), R[R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%], >Q, >(>),>[,>],~(.
 Created: 06/18/98 - 10:30. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

Table B.4.2
Outpatient Physician - Price

	Expense per Unit of Service	Annual Trend
	<u>Year End 06/97</u>	<u>Percent</u>
Outpatient Physician		
Total	\$81	2 %
Medical	55	0
Visits & consultations	54	5
Minor surgery codes	98	6
X-ray/lab interpretations	57	-1
Diagnostic non-surg codes	108	3
Therapeutic non-surg codes	71	22
NOS	35	-9
Surgical	628	2
Surgery - diagnostic	379	2
Surgery - therapeutic	923	4
Surgery - NOS	1,073	N.M.
Assistant surgeon	533	13
Anesthesia	355	-1
MH/CD	75	2
Visits - psychiatric codes	77	0
Visits - non-psych codes	64	9
Other - psychiatric codes	70	1
Other - non-psych codes	92	3

TABLE PARAMETERS

Period: Paid 07/01/95 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
Enrollment: Employees - 91,353 Enrollees - 182,196
Note: Price is based on covered expense per unit of service. Group 77 Composition: DI, DZ, DQ, D(D), D[D], MZ, MQ, M(M!,MR,M), M@, MS, M[,M#, MT, M], R(R), R[,R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%], >Q, >(,>),>[,>],~(.
Created: 06/18/98 - 10:30. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

Table B.3.3
Outpatient Miscellaneous - Utilization

Outpatient Miscellaneous	Unit of Service		Units of Service per 1,000 Enrollees	
	Year End	Percent	Annual Trend	
	06/97		Percent	Actual
Total	1,608,188	100 %	3 %	8,827
X-ray	191,729	12	3	1,052
High Cost Diagnostic	26,063	2	11	143
Other Diagnostic	132,941	8	0	730
Therapeutic	24,602	2	6	135
NOS	8,123	1	20	45
Prescription Drugs	1,347,954	84	-4	7,398
Indemnity Plan	278,277	17	-18	1,527
Card Program	647,654	40	5	3,555
Mail Order Program	422,023	26	-7	2,316
Chiropractor	68,505	4	3	376
Professional	9,212	1	-34	51
X-ray	1,559	0	9	9
NOS	57,734	4	14	317

TABLE PARAMETERS

Period: Paid 07/01/95 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
 Enrollment: Enrollees - 182,196 Employees - 91,353
 Note: Units of service represent values as recorded by the claims payor. Group 77 Composition: DI, DZ, DQ, D(,D), D[,D], MZ, MQ, M(,M!,MR,M), M@, MS, M[,M#, MT, M], R(,R), R[,R], ZQ, Z(,ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %, %[,%], >Q, >(, >), >[, >], ~(.
 Created: 06/18/98 - 10:25. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

Table B.4.3
Outpatient Miscellaneous - Price

	<u>Expense per Unit of Service</u> <u>Year End 06/97</u>	<u>Annual Trend</u> <u>Percent</u>
Outpatient Miscellaneous Total	\$68	10 %
X-ray	203	7
High Cost Diagnostic	575	-3
Other Diagnostic	89	0
Therapeutic	319	12
NOS	536	8
Prescription Drugs	51	9
Indemnity Plan	52	12
Card Program	36	8
Mail Order Program	73	13
Chiropractor	24	2
Professional	29	1
X-ray	55	-4
NOS	23	6

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
 Enrollment: Employees - 91,353 Enrollees - 182,196
 Note: Price is based on covered expense per unit of service. Group 77 Composition: DI, DZ, DQ, D(.D), D[,D], MZ, MQ, M(,M!,MR,M), M@, MS, M[,M#, MT, M], R(.R), R[,R], ZQ, Z(,ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%, >Q, >(, >), >[, >], ~(.
 Created: 06/18/98 - 10:31. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

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Table B.3.4
Outpatient Miscellaneous - Utilization - HOPD Category

	Unit of Service		Units of Service per 1,000 Enrollees	
	Year End	Percent	Annual Trend	Actual
Hospital Outpatient Dept.	06/97		Percent	
Total	624,373	100 %	3 %	3,427
X-ray	109,384	18	2	600
High Cost Diagnostic	18,766	3	9	103
Other Diagnostic	65,907	11	-3	362
Therapeutic	17,157	3	10	94
NOS	7,554	1	21	41
Laboratory	184,191	30	5	1,011
X-ray/Lab - NOS	0	0	N.M.	0
OP Surgery Facility	7,637	1	-13	42
Emergency Room - NOS	41,885	7	-8	230
	39,727	6	-5	218
	44,758	7	12	246
	182,165	29	4	1,000
	14,626	2	-6	80

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
 Enrollment: Employees - 91,353 Enrollees - 182,196
 Note: Price is based on covered expense per unit of service. Group 77 Composition: DI, DZ, DQ, D(D), D[,D], MZ, MQ, M(M!,MR,M), M@, MS, M[,M#, MT, M], R(R), R[,R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%, >Q, >(,>),>[,>],~(.
 Created: 06/18/98 - 10:31. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

Table B.4.4
Outpatient Miscellaneous - Price - HOPD Category

	Expense per Unit of Service	Annual Trend
	Year End 06/97	Percent
Hospital Outpatient Dept.		
Total	\$172	0%
X-ray	260	7
High Cost Diagnostic	586	-4
Other Diagnostic	104	0
Therapeutic	374	11
NOS	551	6
Laboratory	49	4
X-ray/Lab - NOS	0	N.M.
OP Surgery Facility	986	N.M.
Emergency Room - NOS	144	6
Therapies	131	19
Drug/Supplies	131	3
HOPD - NOS	214	-5
Other	438	-8

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
 Enrollment: Employees - 91,353 Enrollees - 182,196
 Note: Price is based on covered expense per unit of service. Group 77 Composition: DI, DZ, DQ, D(D), D[D], MZ, MQ, M(M!,MR,M), M@, MS, M[,M#, MT, M], R(R), R[,R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%, >Q, >(,>),>[,>],~(-
 Created: 06/18/98 - 10:31. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

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Table B.3.5
Outpatient Miscellaneous - Utilization - Preventive Category

	Unit of Service		Units of Service per 1,000 Enrollees	
	Year End	Percent	Annual Trend	Actual
	06/97		Percent	
Preventive Misc. Total	184,835	100 %	6 %	1,014
Physical Examinations	14,571	8	28	80
PAP Smear	15,687	8	2	86
Mammogram	16,959	9	4	93
Immunization	32,354	18	29	178
Well Baby Care	3,643	2	7	20
Colon Cancer Screening	8,159	4	8	45
Eye Examinations	9,446	5	3	52
Diabetes	11,131	6	8	61
Urinalysis	36,656	20	-1	201
Cholesterol Test	8,335	5	-2	46
Chest X-ray	26,056	14	-8	143
Tuberculosis	1,816	1	-14	10
Phenylketonuria	22	0	N.M.	0
Dental Prophylaxis	0	0	N.M.	0
Dental Fluoride Application	0	0	N.M.	0
Dental X-rays	0	0	N.M.	0
Other Preventive Screening	0	0	N.M.	0

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
 Enrollment: Employees - 91,353 Enrollees - 182,196
 Note: Units of service represent values as recorded by the claims payor. Group 77 Composition: DI, DZ, DQ, D(,D), D[,D], MZ, MQ, M(M!,MR,M), M@, MS, M[,M#, MT, M], R(,R), R[,R], ZQ, Z(,ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%], >Q, >(, >), >[, >], ~(.
 Created: 06/18/98 - 10:25. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

Table B.4.5
Outpatient Miscellaneous - Price - Preventive Category

	Expense per Unit of Service	Annual Trend
	Year End 06/97	Percent
Preventive Misc. Total	\$41	8%
Physical Examinations	63	9
PAP Smear	15	0
Mammogram	78	-3
Immunization	48	31
Well Baby Care	48	12
Colon Cancer Screening	7	0
Eye Examinations	40	5
Diabetes	11	-8
Urinalysis	8	-11
Cholesterol Test	13	-7
Chest X-ray	93	9
Tuberculosis	9	0
Phenylketonuria	13	0
Dental Prophylaxis	0	N.M.
Dental Fluoride Application	0	N.M.
Dental X-rays	0	N.M.
Other Preventive Screening	0	N.M.

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97. Trends based on 24 months of data, regressed using annual data.
 Enrollment: Employees - 91,353 Enrollees - 182,196
 Note: Price is based on covered expense per unit of service. Group 77 Composition: DI, DZ, DQ, D(D), D[D], MZ, MQ, M(M!,MR,M), M@, MS, M[,M#, MT, M], R(R), R[,R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %, %[%, >Q, >(,>,>[,>],~(.
 Created: 06/18/98 - 10:31. Expense & Utilization Monitoring Module. Session KANSEU2 (Session ID - AG).

CHAMP National Database - M9706
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Table A.1
Medical Monthly Enrollment Summary - By Relation

Monthly						12- Month Rolling Average				
Date	Total	Employees	Spouses	Children	Family Size	Total	Employees	Spouses	Children	Family Size
Jul - 96	185,165	92,546	53,769	38,850	2.00					
Aug - 96	184,480	92,268	53,536	38,676	2.00					
Sep - 96	184,385	92,189	53,486	38,710	2.00					
Oct - 96	183,525	91,840	53,194	38,491	2.00					
Nov - 96	182,783	91,467	52,965	38,351	2.00					
Dec - 96	182,914	91,439	52,994	38,481	2.00					
Jan - 97	182,621	91,265	52,894	38,462	2.00					
Feb - 97	181,682	90,915	52,741	38,026	2.00					
Mar - 97	180,485	91,003	52,052	37,430	1.98					
Apr - 97	180,450	90,965	52,010	37,475	1.98					
May - 97	180,499	90,937	52,016	37,546	1.98					
Jun - 97	177,357	89,402	51,316	36,639	1.98	182,196	91,353	52,748	38,095	1.99

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97.
Note: Price is based on covered expense per unit of service. Group 77 Composition: DI, DZ, DQ, D(D), D[,D], MZ, MQ, M(M!,MR,M), M@, MS, M[,M#, MT, M], R(,R), R[,R], ZQ, Z(,ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%], >Q, >(,>),>[,>],~(.
Created: 06/22/98 - 9:03. Enrollment Analysis Module. Session KANSEU1 (Session ID - AG).

Table B.1
Medical Monthly Enrollment Summary - By Relation

Age	Total				Male				Female			
	Total	Employees	Spouses	Children	Total	Employees	Spouses	Children	Total	Employees	Spouses	Children
Total	182,196	91,353	52,748	38,095	86,698	62,184	5,270	19,244	95,498	29,169	47,478	18,851
<18	27,850	0	0	27,850	14,027	0	0	14,027	13,823	0	0	13,823
18-29	17,036	5,379	1,830	9,827	8,259	2,737	479	5,043	8,777	2,642	1,351	4,784
30-44	26,944	15,508	11,103	333	12,545	10,203	2206	136	14,399	5,305	8,897	197
45-54	21,626	12,201	9,373	52	10,497	9,341	1,136	20	11,129	2,860	8,237	32
55-64	26,780	15,101	11,667	12	12,056	11,364	687	5	14,724	3,737	10,980	7
65-74	36,175	23,645	12,519	11	17,091	16,556	527	8	19,084	7,089	11,992	3
75-84	21,236	15,689	5,539	8	9,662	9,449	209	4	11,574	6,240	5,330	4
85+	4,483	3,769	712	2	2,522	2,495	26	1	1,961	1,274	686	1
Invalid	66	61	5	0	39	39	0	0	27	22	5	0
Ave Age	49.5	60.1	57.2	13.4	49.0	60.2	47.3	13.4	49.9	59.7	58.3	13.4
Distribution by Percent of Grand Total												
Total	100.0	50.1	29.0	20.9	47.6	34.1	2.9	10.6	52.4	16.0	26.1	10.3
≤18	15.3	0.0	0.0	15.3	7.7	0.0	0.0	7.7	7.6	0.0	0.0	7.6
18-29	9.4	3.0	1.0	5.4	4.5	1.5	0.3	2.8	4.8	1.5	0.7	2.6
30-44	14.8	8.5	6.1	0.2	6.9	5.6	1.2	0.1	7.9	2.9	4.9	0.1
45-54	11.9	6.7	5.1	0.0	5.8	5.1	0.6	0.0	6.1	1.6	4.5	0.0
55-64	14.7	8.3	6.4	0.0	6.6	6.2	0.4	0.0	8.1	2.1	6.0	0.0
65-74	19.9	13.0	6.9	0.0	9.4	9.1	0.3	0.0	10.5	3.9	6.6	0.0
75-84	11.7	8.6	3.0	0.0	5.3	5.2	0.1	0.0	6.4	3.4	2.9	0.0
85+	2.5	2.1	0.4	0.0	1.4	1.4	0.0	0.0	1.1	0.7	0.4	0.0
Invalid	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Family Size
1.99

% Enrolled Spouses
57.74

TABLE PARAMETERS

Period: Paid 07/01/96 to 06/30/97.
Note: Group 77 Composition: DI, DZ, DQ, D(D), D[D], MZ, MQ, M(M!,MR,M), M@, MS, M[M#, MT, M], R(R), R[R], ZQ, Z(ZR,Z) ZS, Z[ZT,Z], %E, %I, %Z, %Q, %), %[%], >Q, >(,>,>[,>],~(.
Created: 06/22/98 - 9:03. Enrollment Analysis Module. Session KANSEU2 (Session ID - AG).